



Initial Screening

Date/Time of Referral:	
Referral Source Facility/Phone #:	ACT Staff Member:

Client's name:	D.O.B.	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Client currently Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No	Client's current location:	Client's Contact #:	
Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No Agency:	Guardian Name:	Guardian Contact #:	
Client's diagnosis:			
Pertinent HX/Psychosocial Crisis:			
Any current medical conditions:			
Current Medications:			

Substance abuse concerns:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Any signs of substance dependency:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Any recent drug screens completed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Substance of choice:			

Willing to participate in case management 2-3 times/wk?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has been notified of "no weapons in home" policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Willing to take medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Willing/able to participate in voc rehab & SA services as needed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Does client require assistance with personal care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Difficulty with ADL's:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Current medical issues:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Hx of unsafe behaviors towards others physical/sexual:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Hx of arson:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:



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Sex offender:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Safety Issues:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Current Legal Issues/P.O.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Psychosis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:
Agitation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes explain:

Has client had any hospitalizations? If so, how many and explain circumstances:

Any recent admissions to Psych ER, CRC, or API?

More recent progress notes/labs needed: Yes No

Accepted Declined Deferred

Signature: _____

Plan of Action: _____

Notes:

Follow Up:

Signature: _____