**County of San Diego Mental Health Services**

**MOBILE CRISIS ASSESSMENT**

**Client Name:       Case #:**       **Assessment Date:**

**Program:       \*Unit:       \*SubUnit:**

Type of Contact:  Telephone  Face-to-Face  Telehealth

**Unique Referral Number**:

Does client meet criteria for continued services:  Yes  No  Declined Services

If declined services, why: (Choose an item.)

If Other, explain:

If No or refused; explain rationale as to why client did not meet criteria (Does not meet medical necessity, does not meet level of referral, client is currently physically injured, client has a weapon, there is a current medical emergency, if there an active crime occurring, client is actively violent, and other potential reasons):

If criteria were not met due to a need to contact EMS or Law Enforcement, was coordination provided promptly?  Yes  No; If no, explain:

**Reason(s) for Referral (check all that apply):**

Suicidal Ideation  Grave Disability  Symptoms of Psychosis

Substance Use  Mood-dysregulation  Homicidal Ideation

Danger to Self  Danger to Others  Other

If other, explain :

Is the client under 18?  Yes  No

Is client on Conservatorship?  Yes  No  Unable to Assess

Does client have Regional Center involvement?  Yes  No  Unable to Assess

Does client have CWS involvement?  Yes  No  Unable to Assess

**\*PRESENTING PROBLEM:** *(A summary of your clinical assessment. It should include: how you became involved with client, scene overview, client report, 3rd party report, justify 5150 or lack thereof. Name/age/ethnicity/gender/language spoken/living situation/circumstances for the referral/precipitating event(s)/current symptoms and behaviors (intensity, duration, onset, frequency) impairments in life functioning caused by the symptoms/brief description of current treatment/organizations, or groups involved/strengths/support):*

\*This contact is related to which of the following:

Mental Health  Substance Use  Co-Occurring

\*Is client currently taking medications (prescribed or over the counter): Yes No  Unknown

List Medications:

\*Is client receiving treatment for any medical conditions: Yes No  Unknown

Describe *(include consideration of co-morbid disabilities, intellectual and/or developmental disabilities (I/DD), traumatic brain injury (TBI))*:

\*Does the client have a Primary Care Physician: Yes No  Unknown

If no, has client been advised to seek primary care: Yes No

Primary Care Physician:       Phone Number:

\*Does client identify as a member of a tribal community?

Yes  No  Refuse/Cannot Assess

If YES , has the client seen an Indian Health Care Provider (IHCP) in the previous 12 months or have a preference to receive follow up care from an IHCP?

Yes No  Unknown/Refused

\* Has client received any behavioral health treatment within the last 12 months? If Yes selected, provide treatment history below.

Yes  No Unknown

\*Current and Past Behavioral Health Treatment *(Describe recent hospitalizations, any connections with current MH providers, relevant past psychiatric/SUD history):*

Insurance? Yes No  Unknown

(If Yes, check all that apply)

Medi-Cal

Medicare

Private Insurance/ VA/ Tricare

If client has private insurance, do they have a current behavioral health provider outside the MHP?

Yes  No  Unable to Assess

Outside Provider information, if available:

**SCHOOL INFORMATION:** *(if responses to \*questions are “No”, client not currently in school or not of school age, answers required only as clinically relevant)*

\*Is the contact location on a school/college/university site?

Yes  No  Refused/Unable to Assess

\*Is client currently in school? *(select “Yes” if enrolled but on school break)*

Yes  No  Refused/Unable to Assess

Current School:

If Other:

Current Grade Level:

Does client have an IEP or 504 Plan?  Yes  No  Unable to Assess

Educationally Related Mental Health Services?  Yes  No  Unable to Assess

History of behavioral problems in school?  Yes  No  Unable to Assess

Does client have a history of truancy,  Yes  No  Unable to Assess

suspensions or expulsions?

School violence plan?  Yes  No  Unable to Assess

If any yes answers, describe:

**SOCIAL CONCERNS**: *(responses required as clinically relevant)*

Peer/Social Support  No  Yes  Refuse/Cannot Assess

Substance use by peers  No  Yes  Refuse/Cannot Assess

Gang affiliations  No  Yes  Refuse/Cannot Assess

Family/community support system  No  Yes  Refuse/Cannot Assess

Religious/ spirituality?  No  Yes  Refuse/Cannot Assess

LGBTQ+ identification/engagement  No  Yes  Refuse/Cannot Assess

Justice system  No  Yes  Refuse/Cannot Assess

History of bullying?  No  Yes  Refuse/Cannot Assess History of being bullied?  No  Yes  Refuse/Cannot Assess Victim of violence/abuse?  No  Yes  Refuse/Cannot Assess

Has a preoccupation with violence?  No  Yes  Refuse/Cannot Assess Violent drawings/writings?  No  Yes  Refuse/Cannot Assess Media research on explosives, weapons,

terrorist sites, school shootings?  No  Yes  Refuse/Cannot Assess

Has intended victims?  No  Yes  Refuse/Cannot Assess

Stalking behavior?  No  Yes  Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**POTENTIAL FOR HARM/RISK ASSESSMENT**

\*Current Suicidal Ideation?  Yes  No  Unknown/Refused

\*Specify plan intent and/or ability to carry out the plan:

\*Previous attempts or past suicidal behaviors?

within past 12 months  greater than 12 months  None  Unknown/Refused

\*Describe:

\*Are the client’s current/recent behaviors possibly creating a danger to self *(things to consider: non-suicidal self-injurious behavior, method, severity, frequency, remote vs ongoing)?*

Yes  No Unknown/Refused

\*Explain:

\*Access to weapons/explosives?  Yes  No Unknown/Refused

\*Current Homicidal Ideation Towards Others?  Yes  No  Unknown/Refused

\*Specify if plan, intent and/or ability to carry out the plan:

\*Previous homicidal ideation towards others?

within past 12 months  greater than 12 months  None  Unknown/Refused

\*Explain:

\*Does the client have past behavior of violence *(Things to consider: toward property or animals, toward people, domestic violence, anti-social, intimidation, predatory, restraining orders?*)

within past 12 months  greater than 12 months  None  Unknown/Refused

\*Describe:

\*Identified Victim(s)?  No  Yes \*Tarasoff Warning Indicated?  No  Yes

Reported To:       Date:

\*Were there multiple victims identified?  Yes  No

\*Victim(s) name and contact information *(Give victim information, time/date, and method of notifying the victim. Provide the Tarasoff warning details):*

\*Is the client’s current/recent behavior possibly creating a danger to others?

Yes  No  Unknown/Refused

\*Describe:

\*Gravely Disabled?  Yes  No  Unknown/Refused

\*If yes, describe *(Explain why client did or did not meet criteria. Be very specific and clear. Gravely disabled is the inability to procure and/or utilize food, clothing, and/or shelter):*

\*Current Abuse or Domestic Violence:  No  Yes  Unknown/Refused to answer

\*If yes, describe situation (*identify parties involved, current restraining or protective order in place, etc)*:

\*Child/Adult Protective Services Notification Indicated?  Yes  No

\*History of Trauma?  Yes  No  Unknown/Refused to answer

\*Describe:

\*Recent Substance Use?  Yes  No  Unknown/Refused

\*If Yes, Describe:

\*History of substance use or treatment for substance use?  No  Yes  Unknown/Refused

\*If Yes, Describe:

\*Describe Factors Increasing Risk *(What are the barriers to client being successful in the community: Why is MCRT/PERT being utilized?)*:

**OUTCOME/ DISPOSITION**

Safety Plan: Including Plan, Details of Safety Plan:

Describe Protective Factors/Strengths: *(strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others; include consideration of cultural factors including but not limited to tribal community engagement, LGBTQ+ identification, and deaf/hard of hearing community engagement)*:

\*Describe Outcome of Encounter*:(What criteria did the client meet? Referrals offered? Include (if client refused the referrals. Tarasoff details)*:

**CARE COORDINATION:**

Which of the following providers were contacted by the Clinician? *(check all that apply):*

Outpatient Treatment Provider  Psychiatrist  School Representative

Probation Officer  CWS Worker  APS worker

LECC/Other LE agencies  Conservator’s Office  Residential Treatment Provider  Other  Not Applicable  Regional Center

Indian Health Care Provider (IHCP)

For any item indicated, provide documentation as to the nature of the contact or why not applicable:

**Signature of Staff Completing Assessment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      

Signature Date Time

Printed Name:       CCBH ID number: