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| county of San Diego Child welfare servicesmental health assessment and recommendation Please check: ❑ Initial assessment ❑ Follow-up assessment  Instructions: This youth is being referred for a MHA based on a CANS screening score that is set to a low threshold to ensure that assessments identify or rule out the need for mental health treatment. | | | | | |
| Confidential Client Information Confidential | | | | | |
| Client Name: Click here to enter text. | | | Gender Identification: | | DOB: 00/00/0000 |
| PSW Name: Click here to enter text. | | | | PSW Phone #: Click here to enter text. | |
| **Diagnostic Impressions and Other Clinical or Medical Considerations** | | | | | |
| Diagnostic Impressions: Click here to enter text. | | | | | |
| Other Areas of Needs (Mental & Physical Health): Click here to enter text. | | | | | |
| **Presenting Mental Health Problem, Symptoms, Functional Impairment** | | | | | |
| Are there any current symptoms, if so please list w/ frequency and duration: Click here to enter text. | | | | | |
| Is client significantly impaired in an important area of life functioning or development at risk as a result of their symptoms or diagnosis? If yes, please describe.Click here to enter text. | | | | | |
| Hx of Trauma and/or Abuse?  Yes  No | | If Yes, explain: Click here to enter text. | | | |
| Substance Use:  N/A  HX  Current | | Drug(s) of choice: Click here to enter text. | | | |
| If current substance use, describe impact on functioning: Click here to enter text. | | | | | |
| Current Risk  Assessment: | Suicidal -  N/A  Ideation  Plan  Intent  History of harming self | | | | |
| Homicidal -  N/A  Ideation  Plan  Intent  History of harming others | | | | |
| Current Risk Assessment Additional Information: Click here to enter text. | | | | | |
| Client Strengths (i.e., motivated, employed, strong social supports): Click here to enter text. | | | | | |
| **Medications (Psychiatric, Medical, & OTC medications)** | | | | | |
| Name of Medication w/ Dosage or N/A: Click here to enter text. | | | | | |
| **Screening Tools (indicate name and results of all screening tools administered)** | | | | | |
| Name of Screening Tool: Click here to enter text.  Results: Click here to enter text. | | | | | |
| **Treatment** | | | | | | |
| Based on your assessment would the child / youth require mental health services at this time? Click here to enter text. | | | | | | |
| Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support): Click here to enter text. | | | | | | |
| **Provider Information** | | | | | | |
| Name/Licensure: Click here to enter text. Address / Phone: Click here to enter text. | | | | | | |
| Provider Signature: Click here to enter text. Date: Click here to enter text.  Provider: Submit the completed MHA to Optum TERM at Fax: 1 (877) 624-8376 within 14 days of MHA appointment.  Optum TERM will be responsible for forwarding completed Mental Health Assessment forms to the Protective Service Worker. | | | | | | |