(**Due to Optum TERM within 14 calendar days of the initial authorization start date)**

**I received and reviewed the following records provided by the PSW (required prior to the intake assessment):**

Detention Hearing Report

Jurisdiction/Disposition Report

Copies of significant additional court reports

Copies of all prior psychological evaluations and Treatment Plans for the client

All prior mental health and other pertinent records

Copies of History & Physical and Discharge Summary written by psychiatrist

For Voluntary Services cases: Summary of case information and protective issues

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| --- | --- | --- |
| Facilitator: | Phone: | Agency: |
| SW Name: | SW Phone: | SW Fax: |
| Date of Intake: | | |
| **DEMOGRAPHIC INFORMATION**  The client is  and self-identifies as . The client’s preferred language is .  Client states that the reason for referral to treatment is [brief description reflecting client’s understanding for referral]:      .  This case is currently . Client  the allegations of sexual abuse.  Client or family have immigrated to the United States to escape war, persecution, or poverty  Yes  No If “Yes”, describe how immigration history and/or cultural/identity factors may have influenced client’s understanding of the protective issues or willingness to collaborate with CWS | | |

**MENTAL STATUS EXAM & ASSESSMENT RESULTS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mental Status/Psychiatric Symptom Checklist:**  **The following current symptoms were reported and observed:**   |  |  |  |  | | --- | --- | --- | --- | | Anhedonia | Dissociative reactions | Flashbacks | Isolation | | Anxious mood | Distorted blame | Homicidality | Psychomotor agitation | | Appetite disturbance | Distressing dreams | Hopelessness | Sleep disturbance | | Avoidance | Euphoric mood | Intrusive memories | Somatic complaints | | Concentration challenges | Euthymic mood | Irritable mood | Suicidality | | Denial | Exaggerated startle response |  | Other: | | Depressive mood | Fatigue |  |  | |
| **Screening Tool Results** (indicate name and results of all tests administered):   |  |  | | --- | --- | | Michigan Alcohol Screening Test (MAST) | Score:       Rating: | | Drug Abuse Screening Test (DAST) | Score:       Rating: | | Other Screening Tool Administered: | Results: | | Other Screening Tool Administered: | Results: |   **Strengths and Barriers** (indicate client’s readiness to change, barriers to treatment, and strengths):      .  **Level of commitment** to attend, participate and change through the treatment program. This commitment may vary from none to a moderate level of commitment at the time of intake:      . |
| Client is appropriate for Sexual Abuse Protection group treatment (non-offending/non-protecting parents)  Additional suggestions to SW for adjunctive treatment while client is in Sexual Abuse Protection group (if applicable):  Client is **not** appropriate for Sexual Abuse Protection group (client to be discharged)  Reason/s client is not appropriate for group at this time:  Actively abusing drugs & alcohol; chemical dependency treatment is to precede treatment for child abuse  Seriously emotional disturbance, requires that appropriate psychiatric and medical care to be addressed prior to group involvement  Unable to tolerate involvement in a group (e.g., due to personality characteristics)  Other (describe):  Recommended alternative treatment:  Additional information referring party should know, including additional clinical concerns that require adjunctive treatment:  Date SW Notified: |

**DIAGNOSIS**

List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

The Primary Diagnosis should be listed first.

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| **ID (ICD-10)** | **Description** | **Corresponding DSM-5-TR Diagnostic Code or V Code** | **Corresponding DSM-5-TR Diagnostic Description or V Code Description** |
|  |  |  |  |
|  |  |  |  |

**GOALS TO ADDRESS IN TREATMENT**

Based on Levenson & Morin (2001) *Treating Nonoffending Parents In Child Sexual Abuse Cases: Connections For Family Safety,* Table 1.2 Criteria for Determining Non-offending Parent’s Competency for Reducing the Risk of Child Sexual Abuse (CSA).

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| --- |
| * Name or describe at least 5 feelings parents have when their child has been sexually abused * Describe and discuss parent’s own feelings since finding out about the sexual abuse * Describe strategies the parent has used for expressing or managing these feelings in appropriate, adaptive ways * Describe the five types of denial of sexual abuse * Discuss own denial in group, reasons for the denial, and triggers for denial. * Spontaneously place responsibility for the abuse on the offender * Describe ways in which sexual abuse affects children * Spontaneously express empathy in group for the child and what the child has experienced * Share in group the specific statements and behaviors parent has provided to the child that reflect support, acceptance, and validation * Identify the emotional and/or behavioral effects of child sexual abuse and how to effectively and appropriately manage them if they appear. * If sexually abused as a child, can spontaneously describe how own abuse affected parent’s ability to recognize or intervene in her child’s sexual abuse * Describe offender patterns of grooming, triggers, and/or opportunities/high risk situation * Describe offender’s relapse prevention plan and how parent will support partner’s relapse prevention plan * Describe components of safety planning: prevention and intervention * Describe own prevention plan to keep child safe * Describe own intervention plan that parent will use if needed to keep child safe * Spontaneously describe how these prevention and intervention strategies have been implemented or are in process of being implemented * Name or describe at least 5 feelings parents have when their child has been sexually abused   **Additional Treatment Goals (if indicated for this client):** |

**SIGNATURE**

|  |  |
| --- | --- |
| Provider Printed Name: | License/Registration #: |
| Signature: | Signature Date: |
| Provider Phone Number: | Provider Fax Number: |
| ***If an intern or practicing at the CASOMB Associate level of certification:*** | |
| Supervisor Printed Name: | License type and #: |
| Supervisor Signature: | Date: |

Submit Group Intake and Progress Report Forms to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved reports to the SW.

Date faxed to **Optum TERM at: 1-877-624-8376**: