|  |  |
| --- | --- |
| ESP Name:        | ESP Phone:        |
| Location of Service:        | Date:        | Time:        |
| Referral Source:        | Referral Phone:        |
| **Demographics** |
| Name:        |
| Gender:       | Marital status:       |
| Street Address:       |
| City, State, Zip:       |
| Phone:        | Living Situation:        | Homeless: [ ]  Yes [ ]  No |
| Emergency Contact (name, relation, phone):       |
| Primary Language:       | Interpreter used: [ ]  Yes [ ]  No; if **yes**, explain:       |
| **Presenting Concerns** |
| Presenting Problem:        |
| Precipitating Factors:        |
| **Legal** |
| Legal guardian: [ ]  Yes [ ]  No; if **yes**, explain:       |
| Rogers guardian: [ ]  Yes [ ]  No; if **yes**, explain:       |
| Healthcare proxy: [ ]  Yes [ ]  No; if **yes**, explain:       |
| Does the person have involvement in the legal system (i.e. legal charges, parole / probation, registered sex offender, other)? *specify if current or historical* : [ ]  Yes [ ]  No; if **yes**, explain:       |
| **Collaterals** |
| ***Type*** | ***Name*** | ***Telephone*** | ***Contacted*** | ***Agency*** |
| PCC / PCP |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| Clinician |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| Psychiatric Prescriber  |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| DMH |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| DDS |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| DCF |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| DYS |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| School / Residential |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| Family / Sig. Other |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| Other |       |       | [ ]  Y [ ]  N [ ]  LM |       |
| Comments:        |
| **Medical / Physical** |
| Please note any special medical considerations (i.e. recent medical admissions, pregnancy, diabetes, sleep apnea, catheters, O2, dialysis, sutures, open wounds, seizures, infectious diseases, other):       |
| Medical equipment needed (i.e. CPAP, wheelchair, other): [ ]  Yes [ ]  No; if **yes**, does the person have equipment? Explain:       |
| Can person ambulate without assistance? [ ]  Yes [ ]  No; if **no**, explain:       |
| Can person perform ADLs independently? [ ]  Yes [ ]  No; if **no**, explain:       |
| Allergies reported (food, medications, other): [ ]  Yes [ ]  No; if **yes**, explain:       |
| (If Opioid overdose) Immunodeficiency virus, Hep C, and Tuberculosis **RISK**:       |
| **Medications** |
| ***Medication*** | ***Dosage*** | ***Frequency*** | ***Route*** | ***Prescriber*** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| Comments on medications (past or present):       |
| **Relevant History** |
| Family History (past or present):       |
| Trauma History:       |
| **Addiction** |
| Current use of substances and / or addiction? [ ]  Yes [ ]  No; if **yes**, explain:       |
| Was a toxicology screen performed? [ ]  Yes [ ]  No; if **yes**, results:       |
| Was Narcan administered in the past 30 days? [ ]  Yes [ ]  No; if **yes**, explain (include date / time):       |
| ***Substance / Type*** | ***First use / Age of Onset*** | ***Last Use*** | ***Quantities*** | ***Duration / Frequency*** | ***Comments*** |
| Alcohol |       |       |       |       |       |
| Cannabis |       |       |       |       |       |
| Cocaine / Crack |       |       |       |       |       |
| Heroin |       |       |       |       |       |
| Opiates / Narcotics |       |       |       |       |       |
| Benzodiazepines |       |       |       |       |       |
| Stimulants |       |       |       |       |       |
| Hallucinogens |       |       |       |       |       |
| Prescription |       |       |       |       |       |
| Other (i.e. food, sex, gambling, tobacco, etc.):       |       |       |       |       |       |
| Additional Information (may include non-current history and must include consequences of use in case of opioid overdose):       |
| **Most Recent Acute Admission(s) and Treatment History***(Inpatient, Detox, CCS, EATs, PHP, Outpatient, other)* |
| ***Dates of Service*** | ***Type of Service*** | ***Provider*** | ***Response to Treatment*** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Comments:       |
| **Mental Status Exam / Risk Assessment***(within normal limits unless checked, items checked are addressed in clinical formulation / narrative)* |
|       | Appearance |       | Memory |       | Weight Change |
|       | Eye Contact |       | Insight |       | Energy |
|       | Speech |       | Judgment |       | Future Oriented |
|       | Sleep |       | Impulsivity |       | Concentration |
|       | *\*Harm to Self* |       | Mood |       | Appetite |
|       | *\*Harm to Others* |       | Affect |       | Thought Content |
|       | Perception: Delusions, Hallucinations |       | Orientation: person, time, place, situation |       | Cognitive Functioning: Intellectual Disability, other |
|       | Elopement |       | Sexualized Behavior |       | Fire Setting |
| *\*Harm to Self and Others include: means, accessibility (including access to firearms), lethality of means,* *suicidal / assault history, lethality of attempts / assaults, family history, self-injurious behavior* |
| **Risk and Protective Factors** |
|       |
| **Strengths and Service Preferences** |
| Person’s strengths and service preferences:       |
| Is there a Safety Plan? [ ]  Yes [ ]  No; if **yes**, explain or attach:       |
| **Clinical Formulation / Narrative / Medical Necessity for Further Treatment** |
|       |
| **Diagnosis** |
|  | ***Code*** | ***Diagnosis*** |
| Primary |       |       |
| Secondary |       |       |
| Other |       |       |
| Other |       |       |
| **Identified Needs and Goals for Treatment** |
| 1.
 |
| 1.
 |
| 1.
 |
| **Resolution / Disposition / Treatment Recommendations***(check all that apply)* |
|       | Inpatient Psychiatric |       | CCS Unit |       | Narcotic Treatment Services |
|       | Outpatient MH / SA |       | ESP Follow-up Visit |       | Pregnancy Enhanced SA Services |
|       | Obs. / Intensive Obs. |       | Med Management Visit |       | Urgent Outpatient |
|       | Medical Admission |       | Level IV Detox |       | Self-help / Peer |
|       | Partial Hospitalization |       | EATS (DDART) |       | Returned to Police / Court |
|       | Day Treatment |       | SOAP |       | Refused / Declined Treatment |
|       | CSP |       | ATS |  |
|       | Other (i.e. DDAT, IOP) describe:       |
| **If Applicable** |
| Next Appointment (date, time, location):       |
| Provider:       |
| Accepting Facility:       | Accepting Doctor:       |
| Transported by:       |
| Medications administered: [ ]  Yes [ ]  No; if **yes**, explain:       |
| Restraints used: [ ]  Yes [ ]  No; if **yes**, explain:       |
| Medical clearance provided by:       | Psychiatric consult with:       |
| **Insurance Information** |
| Primary Insurance:       | Policy number:       |
| Authorization number:       | Number of days:       | Next review date:       |
| Person Authorizing:       | Phone number:       |
| Secondary Insurance:       | Policy number:       |
| Authorization number:       | Number of days:       | Next review date:       |
| Person Authorizing:       | Phone number:       |
| Comments (i.e. subscriber):       |
| **Signatures** |
|  | ***Name*** | ***Date*** |
| ESP Clinician (print name / credentials: |       |       |
| ESP Clinician Signature: |       |       |
| Consulted with (print, if applicable): |       |       |
| Other (print, if applicable): |       |       |
| Other signature: |       |       |