YOUTH ACT SCREENING TOOL

Please use the checklist below to help screen prospective referrals for admission. If an individual appears to fit admission criteria, and the individual and family are interested, contact the Youth ACT Supervisor at 651.291.0067, extension 2200 to make the referral, fax this form to 651.209.3259, Attn: Youth ACT Supervisor or email to ACT@guildservices.org. Please note that the intake and screening process can take several weeks. Thank you.

Date of Referral:

Referral Source:

Referent's Phone #:

Client Name:

Date of Birth:

Soc. Sec. #:

Medical Assistance # (if no MA please explain):

Client address:

County of residence:

Client's Phone #:

Guardian's Name and Phone # (if applicable)

Client/Family primary language (is an interpreter needed?):

Planned Housing:

Diagnosis: ***(include description/code; indicate primary / secondary)***
Priority is given to clients diagnosed with emerging psychotic disorders, thought disorders and mood disorders.
Youth ACT is not appropriate for those with Primary diagnosis of Personality Disorder, significant impairment in cognitive functioning or low functioning Autism Spectrum Disorder.

	Code: ___________ ☐1° ☐ 2°
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CASII/LOCUS (level 4 or higher): _________

Current Service Providers:

Name	Agency	Phone
Guardian:		
Psychiatrist:		
Therapist:		
Case Manager:		
Medical Provider:		
Dental Provider:		
Financial Worker:		
Family:		
Other (specify):		
Other (specify):		

Family system:____

Is the family willing to be engaged and accepting of proposed treatment?_________

Is the family willing to take treatment direction from the team/engage in family therapy?_______

What other treatment interventions have been tried and what was the outcome?

____

____

Current Medications: ____

____

Current Sources of Income:______________ _____

Is the client under Civil Commitment? ☐ No ☐ Yes – Date: _________________
Status: ____________

NTP/Jarvis? ☐ No ☐ Yes **ECT order?** ☐ No ☐ Yes

Priority will be given to individuals who meet one of the following criteria. Check all that apply:

☐ Emerging psychotic disorders and/or primary diagnosis of a thought disorder

☐ High utilization of acute psychiatric hospitals and/or psychiatric emergency services
Specify type & approximate # of admissions: _________
Hospital Admission/Discharge dates______ #ER__________

#Crisis Stabilization__________ #Detox_________#Other___

Additional considerations for Youth ACT service - *Check all that apply:*

☐ Co-existing substance use disorder (indicate diagnosis above) of significant duration (e.g., greater than 6 months). **Duration: _______ months.**

What is client's stage of substance abuse treatment? _______

☐ Client poses a risk of harm to (*check all that apply)*: ☐ Self ☐ Others
Explain:____

Describe encounters with criminal justice or legal system: ___________________________
____

Describe history of aggression (verbal, physical, threats, etc.): _____________________
____

Recurrent difficulty in the following functional areas of: ***(check all that apply):***

☐ Interpersonal Relationships
☐ Recognizing and avoiding common dangers
☐ Maintaining personal hygiene
☐ Medication adherence
☐ Sexual health
☐ Housing (homeless, runaway)
☐ Accessing community resources/social support systems
☐ Medical/Dental
☐ Meeting nutritional needs
☐ Benefit/income management
☐ Educational/Vocational
☐ Social/Recreational

☐ Persistent or recurrent difficulty in multiple functional areas (as listed in the preceding question) without significant assistance from others (friends, family or relatives).

☐ The individual is residing in substandard housing, is homeless, or at imminent risk of becoming homeless. ***Specify:*** ____
____

☐ The individual has been unable to obtain/maintain consistent employment and/or role as a student ***Specify:*** ____
____

☐ Other pertinent information: ____
____

Records to attach:

Required for consideration:

☐ Current Diagnostic Assessment with in last 6 months
☐ Medication list

- ☐ Psychiatrist Records
- ☐ If civil commitment involvement all related court orders and Pre-Petition Screening

If available:

- ☐ Functional Assessment
- ☐ CASII/LOCUS
- ☐ Hospital History & Physicals (past 12 months)
- ☐ Interpretive Summary (if possible)
- ☐ Treatment Plan
- ☐ IEP/School records

Youth ACT would require the client to meet with the team at least three times per week, utilize the team Psychiatrist for medication management and when indicated or desired the team therapist. Client and Family need to be actively involved in the treatment planning process.

Youth ACT is focused on psychiatric rehabilitation and skill-building. Please describe in detail the reason for the referral and what specific things the client needs from the Youth ACT Team. _

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____

To Be Completed By Youth ACT Team

☐ Client will be opened with Youth ACT Team, services are medically necessary

☐ Client will not be opened with Youth ACT services. Reason:

____
____

Mental Health Professional's Name: ____
Date: __________________

Signature:

____