A. PREADMISSION FACE SHEET

1. PERSONAL INFORMATION

Name: _____ DOB: _____ Age: _____
First Middle Last

Address: _____
Street City State Zip code County

SSN: _____ - _____ - _____ Gender: _____ Race: _____ Hispanic origin? _____
(Optional)

Primary language: _____ Height _____ Weight _____ Hair Color_____ Eye Color_____

Phone: (____)_____ Marital status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Military Status: _____ VA contacted: ☐ No ☐ Yes (_____)
Name Phone

2. PREADMISSION SCREENING ENCOUNTER INFORMATION

Date: _____ Evaluation start time: _____ Evaluation end time: _____ Location: _____

Referral Source: _____ Evaluating CSB/BHA: _____ Consumer ID# _____

CSB of Residence: _____ CSB contacted?: ☐ No ☐ Yes (_____)
Name Phone

REACH program contacted: ☐ N/A ☐ No ☐ Yes (_____)
Name Phone

Petitioner Name/Contact Information:_____

ECO: ☐ No ☐ Yes: ☐ Magistrate issued ☐ Law enforcement initiated; Date/Time ECO Executed:_____

Disposition: ☐ Release ☐ Referral ☐ Safety Plan ☐ CSU ☐ Voluntary ☐ Recommitment ☐ TDO

☐ Other _____ Psych Bed Registry Query # _____ Facility: _____

Case/TDO # _____ If change of facility, name of new facility:_____

3. CONTACT INFORMATION & COLLATERAL SOURCES (including health care agent(s))

Name: _____ Relationship: _____ Phone: (____)_____

Address: _____
Street City State Zip code County

Name: _____ Relationship: _____ Phone: (____)_____

Address: _____
Street City State Zip code County

Source(s) of Medical History, Medication, & Collateral Information	☐ Person ☐ Family member (name and relationship): _____ ☐ Others (e.g., medical staff, law enforcement):_____ ☐ Medication containers ☐ Medical records (specify): _____ ☐ Collateral sources were unavailable **>> Explain:**

4. HEALTHCARE INFORMATION AND MEDICAL HISTORY

Advance Directive: ☐ No ☐ Yes ☐ Unknown If yes, obtained? ☐ No ☐ Yes

If not obtained, location: _____
If obtained, AD includes: ☐ Medical ☐ Mental health ☐ End-of-life

Insurance: ☐ Medicaid ☐ Medicare ☐ None ☐ Other: _____ ☐ Unknown

First plan # _____ If applicable, second plan #: _____

Income: ☐ SSI ☐ SSDI ☐ Unknown ☐ Other

Medical History and current medical issues (☐ *If checked, see attached medical information*)

Allergies(including food) or adverse side effects to medications: ☐ Yes ☐ No ☐ Unknown
If yes, explain:

Is the person pregnant? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Current Medications: ☐ No ☐ Yes ☐ *If checked, see attached medication list*

Name	Dose	Schedule	Prescriber

Recent medication change? ☐ Unknown ☐ No ☐ Yes >> Explain:

5. LEGAL STATUS

Code value:_____

Details:

Contact Person:

B. RISK ASSESSMENT DETAILS

1. REASON FOR REFERRAL

2. CURRENT AND HISTORICAL RISK INDICATORS

>> Suicidal Ideation/Behavior: Screen for Current and Historical <<

Current & Historical Thoughts and Means	Comments (details for each item that is applicable, including timeframe)	None known/ reported
Suicidal Thoughts		☐
Suicide Plan		☐
Suicidal Intent		☐

Access to Means		☐
Self-Harm		☐
Suicide Attempt(s)	(including if attempt was stopped by someone or something, or attempt made when others around)	☐

Additional information, if applicable. *(In cases where the risk assessment cannot be completed, you may document the reason(s) here.)*

>> Physical Harm Ideation/Behavior: Screen for Current and Historical <<

Current & Historical Behavior	Comments (details for each item that is applicable, including ability to carry out thoughts/plans and timeframe)	None known/ reported
Threats; thoughts or plans to harm		☐
Expressions of aggression or anger		☐
Fight or attempted fight		☐
Other:		☐
Past physical harm ideation/ behavior		☐

Additional information, if applicable. *(In cases where the risk assessment cannot be completed, you may document the reason(s) here.)*

>> Inability to Care for Self: Screen for Current and Historical <<

Evidence of decreased ability to provide for basic needs and/or protection as a result of mental illness:
☐ None known/reported ☐ Unable to seek basic nourishment ☐ Unable to seek shelter (not just lack of access)
☐ Clothing unsuitable for weather ☐ Recklessness (spending, safety) ☐ Serious neglect of hygiene/ADL's
☐ Serious neglect of medical care ☐ Other:
Comments:

**For minors, ability to care for self is defined in terms of what would be expected for a minor of a similar age and inability is evidenced by delusionary thinking or a significant impairment of functioning hydration, nutrition, self-protection, or self-control.*

3. OTHER HISTORICAL RISK FACTORS

Evidence of Impulsivity/Self-Control

Behavior	Comments (details for each item that is applicable)	None known/ reported
Non-suicidal self-injury		☐
Reckless behavior		☐
Difficulty following through with safety plans		☐
Revocation/violation of probation, supervised release, or other such supervision		☐
Did not follow recommended treatment plan *(e.g., MOT, outpatient)*		☐

Substance Use Assessment

☐ No current use reported ☐ No history of use reported ☐ Historical use *only* ☐ Declined to answer

Drug	Frequency	Amount	Method	Last Use Date	Age of 1st Use

History of significant withdrawal symptoms:

☐ Seizures ☐ DTs ☐ Other:_____

Lab Results:

Blood alcohol level: _____ Toxicology screen: _____

Other Risk and Historical Factors

☐ None known/reported ☐ Family or peer suicide ☐ Childhood abuse/neglect

☐ Other trauma: _____

☐ Recent discharge from inpatient psychiatric (within last 60 days) ☐ Owns or has access to firearm

☐ Other:

4. PSYCHIATRIC TREATMENT

Is the person currently in treatment? ☐ Yes ☐ No ☐ Unknown

If yes: Name of facility/provider: _____

Date treatment began: _____ Frequency of treatment: _____

History of treatment? ☐ Yes ☐ No ☐ Unknown

If yes, list most recent providers/facilities, type of treatment, and dates of service:

Provider or Facility	Treatment type (e.g., outpatient, inpatient, detox)	Dates of service

History of treatment…
with psychiatric medication? ☐Yes ☐ No ☐ Unknown
in state hospital? ☐Yes ☐ No ☐ Unknown (name and date: _____)
in a crisis stabilization unit? ☐Yes ☐ No ☐ Unknown (name and date: _____)

Does the person express treatment preferences? ☐Yes ☐ No ☐ Unknown
If yes, the person's preferences are:

5. CURRENT SYMPTOMS AND MENTAL STATUS

Diagnosis (ICD-10; (P) for provisional, (H) for historical)

Symptoms (Check all that apply)

☐ High anxiety, stress, emotional pain ☐ Hopelessness ☐ Anger ☐ Feeling burdensome to others
☐ Negative appraisal of illness or recovery ☐ Social withdrawal ☐ Increased depressive symptoms

Capacity (For adults and minors age 14 and older)

☐ The individual appears to have capacity to consent to voluntary psychiatric admission because able to:
- ☐ Maintain and communicate choice,
- ☐ Understand relevant information, and
- ☐ Understand consequences

☐ The individual appears to lack capacity

Mental Status (Check all that apply)

Appearance	☐WNL	☐unkempt	☐poor hygiene	☐tense	☐rigid	☐other:
Motor	☐WNL	☐psychomotor retardation	☐psychomotor agitation	☐tremor	☐restless	☐other:
Behavior	☐WNL ☐tearful	☐agitated ☐easily startled	☐guarded ☐other:	☐manic	☐distracted	☐impulsive
Orientation	☐WNL	☐time disorientation	☐place disorientation	☐person disorientation	☐situation disorientation	☐other:
Speech	☐WNL ☐slurred	☐pressured ☐other:	☐slowed	☐soft	☐loud	☐incoherent
Mood	☐WNL ☐withdrawn	☐depressed ☐anhedonic	☐angry ☐other:	☐hostile	☐euphoric	☐anxious
Affect	☐WNL ☐other:	☐constricted	☐blunted	☐flat	☐labile	☐incongruent with situation
Thought Content	☐WNL ☐ obsessions	☐impaired ☐grandiose	☐unfocused ☐phobias	☐preoccupied ☐ideas of reference	☐delusions ☐ paranoid	☐thought insertion ☐other:
Thought Process	☐WNL ☐ impaired concentration	☐illogical ☐circumstantial	☐concrete ☐loose associations	☐incoherent ☐flight of ideas	☐tangential ☐thought blocking	☐perseverative ☐other:
Sensory	☐WNL	☐hallucinations type:		☐illusions	☐flashbacks	☐other:
Memory	☐WNL ☐other:	☐impaired immediate		☐impaired recent		☐impaired remote
Appetite	☐WNL	☐decreased	☐increased	☐weight loss	☐weight gain	☐other:
Sleep	☐WNL	☐insomnia	☐onset problem	☐maintenance problem	☐hypersomnia	☐other:
Insight	☐WNL	☐some	☐little	☐none	☐blaming	☐other:
Judgment	☐WNL	☐impaired	☐poor	☐other:		

Is there a prior episode of psychosis? ☐ No ☐ Unknown ☐ Yes (if yes, describe in Mental Status Narrative)
Is the person showing symptoms of psychosis? ☐ No ☐ Yes (if yes, describe in Mental Status Narrative)
Mental Status Narrative (description of symptoms checked above):

Engagement, Reliability, Response to Interviewers
Person's report appears reliable and consistent. ☐ Yes ☐ No
Engaged and cooperative with assessment and treatment planning. ☐ Yes ☐ No
Comments (optional):

6. FEASIBILITY OF LESS RESTRICTIVE ALTERNATIVES

	Yes	No	N/A
Suicide			
Available resources are sufficient to address immediate suicide risk and person-specific triggers	☐	☐	☐
Physical Harm			
Available resources are sufficient to address immediate risk of physical harm and person-specific triggers	☐	☐	☐
Inability to care for self and basic needs			
Available resources are sufficient to improve person's ability to care for self and basic needs	☐	☐	☐

Plans for addressing risk in the community -or- **Rationale why less restrictive alternatives not feasible**
(☐ *If checked, see attached safety plan*):

C. PREADMISSION SCREENING SUMMARY

1. PRESENTING SITUATION

Summary of presenting crisis (including person and collateral perspectives):

The person's most significant stressors:

Coping strategies already attempted by the person:

Strengths or moderating factors related to documented risk issues and/or concerns:

Assessment and disposition recommendation summary (including person-specific triggers that could quickly increase risk for suicidal or physical harm or quickly decrease ability to care for self and basic needs, and any available resources or protective factors):

D. CSB RECOMMENDATIONS

ADULT - As a result of the emergency evaluation:

The CSB finds that the person ☐ meets / ☐ does not meet the civil commitment criteria, and the CSB recommends:

- ☐ No further action at this time
- ☐ Voluntary community treatment (if known at time of disposition, facility/provider: _____)
- ☐ Voluntary admission to a crisis stabilization program at _____
- ☐ Voluntary inpatient treatment
- ☐ Temporary detention order
- ☐ Recommitment

The CSB further recommends:

- ☐ Consideration of 10-day inpatient admission by health care agent or guardian consent
  Agent or guardian name: _____
- ☐ Alternative transportation by _____

MINOR - As a result of the emergency evaluation, the CSB recommends:

The CSB finds that the minor ☐ meets / ☐ does not meet the civil commitment criteria, and the CSB recommends:

- ☐ No further action at this time
- ☐ Voluntary community treatment (if known at time of disposition, facility/provider: _____)
- ☐ Voluntary admission to a crisis stabilization program at _____
- ☐ Voluntary inpatient treatment
- ☐ Temporary detention order

The CSB further recommends:

- ☐ Alternative transportation by _____
- ☐ An order directing either or both parents/guardian to comply with conditions relating to minor's treatment

E. NOTIFICATIONS

1. Attempt to obtain person's agreement or objection to legally required notifications (per Va. Code § 32.1-127.1:03(D34))

_____ will be contacted with information directly relevant to their involvement with the person's health care, including location and general condition.

☐ Person agrees ☐ Person objects ☐ Person lacks capacity ☐ Emergency makes impractical to agree/object

2. Required notification to family member or personal representative, including agent in healthcare advance directive (per Va. Code §§ 16.1-337 or 37.2-804.2)

☐ Contact was made with _____via _____

☐ Reasonable attempt was made to contact _____ via _____

Comments:

☐ No notification made because

☐ Notice already provided, or ☐ Contact is prohibited by court order, or ☐ Consent is not available and contact is not in person's best interest, or ☐ Person has capacity and objects

3. Required notification when TDO is <u>not</u> recommended for an adult (per Va. Code §37.2-809)

☐ The evaluator informed

☐ the petitioner (_____),

☐ the onsite treating physician (_____), and

☐ the person who initiated emergency custody (_____; or check here ☐ if the person was not present).

☐ Person who initiated emergency custody was informed that CSB would facilitate communication with the magistrate upon request

☐ Person who initiated emergency custody requested to speak with magistrate regarding recommendation, so evaluator made arrangements

_____ _____ _____

Preadmission screening clinician signature Date CSB/BHA

_____

Printed name (Not required if electronically signed)

_____ _____ _____

Preadmission screening clinician signature Date CSB/BHA

_____

Printed name (Not required if electronically signed)

F. CSB Report to Court and Recommendations for the Individual's Placement, Care, and Treatment

Name: _____ Date: _____ Time: _____ ☐am ☐pm

☐ No further treatment required.
☐ Has / ☐Does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for outpatient treatment).
☐ Is / ☐Is not willing to be treated voluntarily (N/A under Virginia Code § 19.2-169.6).
☐ Voluntary community treatment at the ☐ CSB (_____) or ☐ other (_____).
☐ Voluntary admission to a crisis stabilization program (_____).
☐ Adult: Voluntary inpatient treatment because individual requires hospitalization and has indicated that he/she will agree to a voluntary period of up to 72 hours and will give the facility 48 hours' notice to leave in lieu of involuntary admission.
☐ Minor: Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older.
☐ Minor: Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

Minor 16.1-340.4 ☐ Under age 14 ☐ Age 14 or older
(For inpatient treatment only) Parent or guardian ☐ is / ☐ is not willing to consent to voluntary admission.
Because of mental illness, meets the criteria for involuntary admission or mandatory outpatient treatment as follows:
☐The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats, or ☐The minor is experiencing serious deterioration of his ability to care for himself in a developmentally age appropriate manner, evidenced by: ☐delusional thinking or significant impairment of functioning in ☐hydration ☐nutrition ☐self-protection ☐self-control.
☐The minor is in need of compulsory treatment for mental illness and is reasonably likely to benefit from the proposed treatment.
The parent or guardian with whom the minor resides is willing to approve any proposed commitment.
☐Yes ☐No ☐Unavailable If no, such treatment is necessary to protect the minor's life, health, safety or normal development. ☐Yes ☐No
Therefore, the CSB recommends:
☐Involuntary admission and inpatient treatment, as there are no less restrictive alternatives to inpatient treatment.
☐Alternative transportation provided by: _____
☐Mandatory outpatient treatment (16.1-345.2) not to exceed 90 days because ☐less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and determined to be appropriate; and ☐providers of the services have agreed to deliver the services. The minor, if 14 years of age or older, and his parents or guardians ☐have sufficient capacity to understand the stipulations of the minor's treatment, ☐have expressed an interest in the minor's living in the community and have agreed to abide by the minor's treatment plan, and ☐are deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services. And ☐the ordered treatment can be delivered on an outpatient basis by the CSB or a designated provider(s) (_____).
☐The best interests of the minor require an order directing either or both of the minor's parents or guardian to comply with reasonable conditions relating to the minor's treatment. ☐Yes ☐No

Adult 37.2-816
Because of mental illness meets the criteria for involuntary admission or mandatory outpatient treatment* as follows:
☐There is a substantial likelihood of serious physical harm to ☐self or ☐others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any, or
☐There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to lack of capacity ☐to protect him/herself from harm or ☐to provide for his/her basic human needs*
Therefore, the CSB recommends:
☐Involuntary admission and inpatient treatment as there are no less restrictive alternatives to inpatient treatment.
☐Alternative transportation provided by: _____
☐Mandatory outpatient treatment (37.2-817(D)) because ☐less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and ☐are deemed to be appropriate; and the person ☐has agreed to abide by his/her treatment plan and ☐has the ability to do so. The recommended treatment ☐is actually available on an outpatient basis by the ☐CSB or ☐designated provider(s) (_____).
☐Physician discharge to mandatory outpatient treatment following inpatient admission pursuant to 37.2-817(C1)&(C2). ☐The person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission; ☐in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent relapse or deterioration of his condition that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; ☐as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment; and ☐the person is likely to benefit from mandatory outpatient treatment.

_____	_____	_____	_____
Preadmission screening clinician signature	Date	Preadmission screening clinician signature	Date
_____	_____	_____	_____
Print name here (Not required if electronically signed)	CSB/BHA	Print name here (Not required if electronically signed)	CSB/BHA

**Not applicable under Virginia Code 19.2-169.6*

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