# Section A: LINGUISTIC/CULTURAL PREFERENCES

Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you **speak**: ❒ English ❒ Spanish ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you **read**: ❒ English ❒ Spanish ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you **write** in: ❒ English ❒ Spanish ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any rituals or beliefs that may impact your health care? ❒Yes ❒No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As your case manager, how would you like me to address these issues in your care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who makes decisions regarding your health in your family? ❒ Self ❒ Other :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking in CAREWare.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section B: FAMILY AND SOCIAL SUPPORT NETWORK

Have you disclosed to former partner(s) about your HIV status? ❒ Yes ❒ No ❒ N/A

Have you disclosed to your current partner about your HIV status? ❒ Yes ❒ No ❒ N/A, no relationship

Do you know your current spouse/partner’s HIV status? ❒ Yes, positive ❒ Yes, negative ❒ No ❒ N/A

Describe Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have people in your life who are supportive of you? ❒ Yes ❒ No

Do you have a social support system (church, family friend, other)? ❒ Yes ❒ No

If yes, is your support system aware of your HIV status? ❒ Yes ❒ No

If yes, are they supportive? ❒ Yes ❒ No

If not aware of your status, do you have any of these concerns?

❒ Disclosure of HIV status will mean loss of home or living arrangements

❒ Client is not ready to disclose HIV status

❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish to tell anyone else of your HIV status, but need support in doing so? ❒ Yes ❒ No

If yes, who do you need help discussing your HIV status with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you count on or look to for support? (Check all that apply)

❒ No one ❒ Self ❒ Family member ❒ Friend ❒ Spouse/partner

❒ Medical provider ❒ Sponsor ❒ Case manager ❒ Spiritual support person

Would you like to have a stronger support system? ❒ Yes ❒ No

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section C: HOUSING/LIVING SITUATION

|  |  |  |
| --- | --- | --- |
| **Affordable housing priority groups:** | **Yes** | **No** |
| Veteran? |  |  |
| 55+? |  |  |
| Serious mental illness (Schizophrenia, Bipolar, or Major Depression), or chronic substance use? |  |  |
| Chronic homelessness (see definition)? |  |  |

**HUD definition of chronic homelessness:**

Have you been living in a place unfit for human habitation such as a shelter, street, car, abandoned building:

❒ continuously for a year or more OR ❒ at least four episodes in the past three years?

**Current housing status (HRSA/RSR data requirements):**

**Stable/Permanent (**❒ apartments, ❒ houses, ❒ foster homes, ❒ long-term residences, ❒ boarding homes)

**Temporary** (❒ Transitional housing, ❒ temporary stay with family or friends, ❒ temporary placement in an institution (e.g., ❒ hospital, ❒ psychiatric facility, ❒ substance abuse treatment facility, or ❒detoxification center), ❒ hotel or motel paid for without emergency shelter voucher.

**Unstable** (❒ Emergency shelter, ❒ car, ❒ an abandoned building, ❒ a bus/train/subway station/airport, or ❒ outside, ❒ jail, prison, ❒ juvenile detention facility ❒ hotel or motel paid for with emergency shelter voucher.

If housed in an institution or non-permanently housed, will you need help with finding shelter or a place to live once discharged? ❒ Yes ❒ No ❒ NA

Besides you, who lives in your household (including children)?

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Aware of Your HIV Status?** |
|  |  |  |
|  |  |  |

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section D: FINANCIAL PLANNING / EMPLOYMENT STATUS

What kind of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒ N/A currently not working

If not working, would you like help finding employment? ❒ Yes ❒ No

|  |  |
| --- | --- |
| Do you have enough money each month for rent and /or utilities? | ❒ Yes ❒ No ❒ NA |
| Do you have past due medical bills? | ❒ Yes ❒ No ❒ NA |

Employment or financial concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section E: TRANSPORTATION

What is your main source of transportation?

❒ Own car ❒ Bus ❒ Receive ride from family/friends ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will you need help to get to your medical or social service appointments? ❒ Yes ❒ No

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section F: LEGAL NEEDS

Do you need assistance with any of the following that relates to your HIV condition? (*Check all that apply*):

❒ None Needed

❒ Confidentiality concerns

❒ Discrimination

❒ Will

❒ Living will

❒ Power of attorney

❒ Notarial services

Are you on probation or parole? ❒ Yes ❒ No ❒ N/A If yes, until what date? \_\_\_\_\_\_\_\_\_\_\_\_

Is your parole/probation officer aware of your HIV Status? ❒ Yes ❒ No ❒ N/A

Are you required to register as a sex offender? ❒ Yes ❒ No ❒ N/A

Are you a U.S. citizen? ❒ Yes ❒ No \****Ryan White programs CAN serve individuals not lawfully present.\****

If no, what types of documents do you possess? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section G: FOOD/NUTRITIONAL

Have you gained or lost a significant amount of weight in the last 6 months? ❒ Yes ❒ No

If yes, have you gained? \_\_\_\_\_ (lbs gained) \_\_\_\_\_\_ (lbs lost)

If yes, describe this gain or loss and the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking nutritional supplements? ❒ Yes ❒ No

If yes, what supplement(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have access to: (Please check all that apply)

❒ Food pantry? ❒ Food Stamps? ❒ Meals on Wheels? ❒ Other: \_\_\_\_\_\_\_\_\_\_\_

Do you have any physical problems that make it difficult to eat? ❒ Yes ❒ No

If yes, please check all that apply:

❒ Tooth/mouth problems ❒ Swallowing problems ❒ Food allergies

❒ Nausea ❒ Taste alteration problems ❒ Cannot eat certain foods

❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food or nutrition concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section H: FUNCTIONAL (Activities of daily living and home health care)

Does your health keep you from working, doing house work/chores, or going to school? ❒ Yes ❒ No

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have difficulty with any of these activities on a typical day?** | **No, I’m NOT limited** | **I’m limited a little** | **I’m limited a lot** |
| Physical activities you can do, like lifting heavy objects. |  |  |  |
| Physical activities you can do, like moving a table, or carrying groceries. |  |  |  |
| Walking uphill or climbing a few flights of stairs. |  |  |  |
| Bending, lifting or stooping. |  |  |  |
| Walking one block or running. |  |  |  |
| Eating, dressing, bathing or getting on and off the toilet. |  |  |  |

Assistive technology needed:

Physical: ❒ Wheelchair ❒ Scooter ❒ Cane ❒ Walker ❒ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visual/Auditory: ❒ Large-print ❒ Braille ❒ Screen reader ❒ Hearing Aid ❒ Glasses

❒ ASL Interpretation ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cognitive/Learning: ❒ Memory aid ❒ Educational software ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need or use Durable Medical Equipment? (Example: Cane, walker, etc.) ❒ Yes ❒ No

If yes, what DME do you use or what DME to you need? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving in-home care? ❒ Yes ❒ No

If yes, indicate type (skilled nursing, home health aide, OT, PT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Provider** | **Address** | **Phone and Fax** | **Contact Name** |
|  |  |  |  |

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section I: ORAL HEALTH CARE

In the last year, have you had an oral health exam? ❒ Yes ❒ No

If yes, when and where was your last appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please state reasons \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want us to refer you to a dentist? ❒ Yes ❒ No

Dental concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section J: SEXUAL ORIENTATION, GENDER IDENTITY & SEXUAL HEALTH

In the last 12 months, have you been sexually active? ❒ Yes ❒ No

Are you attracted to and/or have sex with:

|  |  |  |
| --- | --- | --- |
| ❒ Men | ❒ Both | ❒ Don’t want to disclose |
| ❒ Women | ❒ Neither |  |

When you are sexually active, how often do you use a condom or other barrier method?

❒ Never ❒ Sometimes ❒ All of the time.

What methods of risk reduction do you use when you are sexually active?

❒ Condom/Barrier use ❒ Dental Dams ❒ Abstinence ❒ None ❒ Not applicable

What method (s) of birth control apply to you? Check all that apply.

❒ Abstinence ❒ Birth control pill ❒ Condoms ❒ Depo Provera

❒ Hysterectomy ❒ IUD/Diaphragm ❒ Spermicide ❒ Tubal ligation

❒ Vasectomy ❒ None ❒ Not applicable

Are you experiencing any concerns with sexual function or sexual relationships? ❒ Yes ❒ No

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section K: MEDICAL HISTORY

Are you currently seeing a primary care provider for your HIV condition? ❒ Yes ❒ No

If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please state the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, would you like for us refer you to a primary care provider? ❒ Yes ❒ No

If no, please state the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last 6 months, have you gone to the **emergency room** (including for mental health)?

❒ Yes ❒ No ❒ Refused to answer ❒ Unknown

In the last 6 months, have you been **admitted** to the hospital (including for mental health)?

❒ Yes ❒ No ❒ Refused to answer ❒ Unknown

Do you want more information on an anal, or vaginal Pap screening or self-breast exams?

❒ Yes ❒ No

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section L: MEDICATION/ADHERENCE

Are you currently taking HIV medications? ❒ Yes ❒ No

If no, please state reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what are they:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other reason why you might miss a dose of medication: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any herbal medicine or supplements for your HIV disease? ❒ Yes ❒ No

If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, refer to Primary Care Physician

Do you have a problem with any of the following? (*Check all that apply*.)

❒ Understanding instructions for taking medications ❒ Storing medications properly

❒ Keeping medical provider appointments ❒ Keeping to dietary restrictions

❒ Picking up prescription at the pharmacy ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section M: PERINATAL / REPRODUCTIVE HEALTH ASSESSMENT

Are you planning on becoming pregnant or on having biological child in the future? ❒ Yes ❒ No

If yes, would you like more information about HIV transmission or risk factors? ❒ Yes ❒ No

*For any parent with a child who is ≤ 2 years old, please complete the following to ensure the child is receiving appropriate treatment/care.*

|  |  |  |
| --- | --- | --- |
|  | **Child 1** | **Child 2** |
| What is the child’s HIV-status? (check only one) [*Answer based on Lab results]* | ❒ Unknown/not tested  ❒ Indeterminate  ❒ HIV-Positive/clinical and CD4 status unknown  ❒ HIV-Negative  ❒ Asymptomatic (HIV infected with no symptoms) | ❒ Unknown/not tested  ❒ Indeterminate  ❒ HIV-Positive/clinical and CD4 status unknown  ❒ HIV-Negative  ❒ Asymptomatic (HIV infected with no symptoms) |
| If answer is *unknown/not tested or indeterminate* does child need to be tested? | ❒ Yes  ❒ No (refer client)  ❒NA | ❒ Yes  ❒ No (refer client)  ❒NA |
| Is your child receiving HIV-related medical care? | ❒ Yes  ❒ No (refer client)  ❒N/A  If yes, where/doctor name & contact info? | ❒ Yes  ❒ No (refer client)  ❒ N/A  If yes, where/doctor name & contact info? |

Are you or is your partner pregnant?

❒ No, not pregnant

❒ Yes, pregnant

If yes, are you currently seeing someone for your prenatal care? ❒ Yes ❒ No

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please refer client:

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment date: \_\_\_\_\_\_\_\_\_\_\_\_ or ❒ client refused

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section N: MENTAL HEALTH AND PSYCHOSOCIAL STATUS

Have you ever been hospitalized because of a mental health concern? ❒ Yes ❒ No

Are you **currently** receiving professional help for any mental health concerns? ❒ Yes ❒ No ❒N/A

If yes, what kind of help? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you on medications for any symptom above? ❒ Yes ❒ No

Prescribed by: \_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please state reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you **ever** received help for any of the above mental health concerns in the **past**? ❒ Yes ❒ No

If yes, what kind of help? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are not taking medication for a symptom above, have you **ever**? ❒ Yes ❒ No

If yes, which medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prescribed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you cope with stress? ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Depression Screening (PHQ-9):** Provide screening.

|  |  |
| --- | --- |
| **PHQ-9 Score:** |  |

**Anxiety Screening (GAD-7):** Provide screening.

|  |  |
| --- | --- |
| **GAD-7 Score:** |  |

**OPTIONAL: Trauma Screening (PC-PTSD):** Provide screening.

|  |  |
| --- | --- |
| **PC-PTSD Score:** |  |

**Suicide/Self-Harm Screening**

Have you ever had thoughts of hurting yourself or of suicide? ❒ Yes ❒ No

If yes, please describe situation: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **currently** having any thoughts about suicide? ❒ Yes ❒ No

If yes, have you thought of a plan to hurt yourself? ❒ Yes ❒ No

If yes, what is your plan (include, time, method, access)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the reasons that would stop you from carrying out your plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Explore the following Risk, Stressor, and Protective Factors with anyone who has attempted or thought of suicide. Discuss this information in safety planning with an individual who is having thoughts of suicide.***

Suicide Risk Factors (do any of the following apply?):

❒ Prior attempt ❒ Social isolation

❒ Drug/alcohol misuse ❒ Chronic disease and disability

❒ Depression or mood disorder ❒ Lack of access to behavioral healthcare

❒ Access to lethal means ❒ Knowing someone who died by suicide

Psychosocial Stressors:

❒ End of a relationship ❒ Death of a loved one

❒ An arrest ❒ Serious financial problems

Suicide Protective Factors:

❒ Effective behavioral healthcare

❒ Connections to individuals, family, community, or social institutions

❒ Life skills including problem solving, coping mechanisms, and ability to adapt to change

❒ Self-esteem and a sense of purpose or meaning in life

❒ Cultural, religious, or personal beliefs that discourage suicide

❒ What do you feel like before these thoughts occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?

❒Internal coping strategies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Homicidal indicators**

Have you had thoughts of harming others **in the past?** ❒ Yes ❒ No

If yes, did you act on that? (Who was harmed? How? When?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes and did not act on them, what were the reasons that kept you from harming them?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you **currently** have thoughts of harming others? ❒ Yes ❒ No

If yes, what are your thoughts? (Who? How? When?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what are some reasons that might stop you from harming others?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you think the person might harm him/herself or others—do not leave client alone, contact your supervisor!**

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section O: SUBSTANCE USE/ALCOHOL USE

**DAST-10:** Provide screening.

|  |  |
| --- | --- |
| **DAST-10 Score:** |  |

**Alcohol Assessment (C.A.G.E.):** Provide screening.

|  |  |
| --- | --- |
| **CAGE Score:** |  |

Are you **currently** in recovery? ❒ Yes ❒ No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has drinking or drug use affected with your relationships with family/friends or work? ❒ Yes ❒ No

Have you smoked >100 cigarettes in your entire life? ❒ Yes ❒ No

If yes, how often do you smoke cigarettes currently? ❒ Every day ❒ Some days ❒ Not at all

If currently still smoking have you tried to quit in the last 12 months?

❒ Yes ❒ No *(If no, discuss smoking cessation with client)*

Do you use any other tobacco or nicotine products? ❒ Pipe ❒ Cigar ❒ Smokeless Tobacco products (snuff, chew)

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section P: VIOLENCE / ABUSE / NEGLECT

Are you currently in a relationship? ❒ Yes ❒ No

Have you ever experienced a violent event? ❒ Yes ❒ No

If yes, please complete Violence Assessment Chart:

**Violence Assessment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type:** | **Victim** | **Perpetrator** | **Witness** | **Current** | **Past** |
| Physical Abuse |  |  |  |  |  |
| Domestic/Partner Violence |  |  |  |  |  |
| Community Violence |  |  |  |  |  |
| Physical Neglect |  |  |  |  |  |
| Emotional Abuse |  |  |  |  |  |
| Elder Abuse |  |  |  |  |  |
| Sexual Abuse |  |  |  |  |  |
| Financial Abuse |  |  |  |  |  |
| Verbal Abuse |  |  |  |  |  |

**\*If experiencing or experienced violence, refer to appropriate emergency services (e.g. Partner/Domestic Violence Hotline, police, etc.)**

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Section Q: EMERGENCY EVACUATION PLAN / CRISIS PLANNING

**In the event of an emergency evacuation, how will client respond:**

❒ Has his/her own transportation

❒ Will leave with family/friends

❒ Shelter in place

❒ Other:

Can client be contacted with the information provided?

Where will the client evacuate to?

Other items reviewed with client regarding emergency evacuation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*\*Counsel client on medication access during evacuation\*\*\*\**

Other Potential Emergency/Crisis (Check all that apply)

❒ Medical; preferred hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒ Threat of an Eviction

❒ Mental Health ❒ Threat of Utility Shut-off

❒ Substance Use Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❒ Arrest Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Manager: Does client have any service need in this section?** ❒ **Yes**  ❒ **No** ❒ **Declined**

**If yes, please document referral information in referral tracking.**

**If no or declined, please state the reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_