Shasta County Mental Health

Access Team
2640 Breslauer Way, Redding CA 96001
(Phone) 530-225-5252 (Fax) 530-225-3870

Start Time:	
Date:	
Clinical Staff Name:	

Why are you here today?

Symptom Scale (Include precipitating trigger events)

Depression: ☐ 1 None ☐ 2 Occasionally ☐ 3 Moderate ☐ 4 Often ☐ 5 Severe

Describe:

Potential for harm to self or others: ☐ 1 None ☐ 2 Occasionally ☐ 3 Moderate ☐ 4 Often ☐ 5 Severe

Describe:

Takes medication regularly: ☐ Daily ☐ 3-4 x/week ☐ None

Current meds:

Decision making skills/judgement: ☐ 1Good ☐ 2 Fair ☐ 3 Bad ☐ 4 Poor

Describe:

Isolation: ☐ 1 None ☐ 2 Occasionally ☐ 3 Moderate ☐ 4 Often ☐ 5 Severe

Describe:

Denies mental illness/addiction: ☐ 1 None ☐ 2 Occasionally ☐ 3 Moderate ☐ 4 Often ☐ 5 Severe

Describe:

Psychotic symptoms: ☐ 1 None ☐ 2 Occasionally ☐ 3 Moderate ☐ 4 Often ☐ 5 Severe

Describe:

Amenable to treatment: ☐ 1 Not at all ☐ 2 Somewhat ☐ 3 Well ☐ 4 Very well ☐ 5 Highly

Describe:

Client:			
Chart #		DOB:	

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Other risk factors: ☐ Recent hospitalization ☐ 5150 ☐ DV ☐ Child Abuse ☐ Elder Abuse ☐ Spouse Abuse

☐ Other: _____

Alcohol & other drug history:

Substance abuse related problems? ☐ Y ☐ N

Previously identified co-occurring disorders? ☐ Y ☐ N

Primary drug choice: _____

Secondary: _____

Tertiary: _____

Has received substance abuse treatment in the past: ☐ Y ☐ N

Where: _____

Mental status exam (mood, affect, etc.):

History of psychiatric illness and treatment:

Relevant family psychiatric history:

Access Team Triage

Client:			
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Plan of action (recommendations for interview):

Functional capacity and supports:

Yes	No		Yes	No	
☐	☐	Stable housing?	☐	☐	Good decision making skills?
☐	☐	In vocational or education programs?	☐	☐	Participates in activities/school/social contacts?
☐	☐	Engaged in community support network?	☐	☐	Denies that s/he has mental illness/addiction?
☐	☐	Family/peer support?	☐	☐	Sleep patterns OK?
☐	☐	Life goals?	☐	☐	Will engage in treatment?
☐	☐	Recovery activities?	☐	☐	Reports auditory or visual hallucinations?
☐	☐	Can manage basic needs in community?	☐	☐	Criminal charges/school suspension/expulsion?
☐	☐	Employment	☐	☐	Other:
☐	☐	Symptoms do not interfere with daily life?			
☐	☐	Linked with a psychiatrist for medications?			Psychiatrist name:
☐	☐	Linked with PCP for medications?			PCP name:

Axis I (1) Axis I (2)

Axis II (1) Axis II (2) Axis IV

Axis III Axis V

LOCUS complete? ☐ **Y** ☐ **N** **GAF:** **Total score:** **Provisional DX:**

Other cultural/language issues/barriers:

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Client disposition:

Urgent care follow-up and plan? ☐ Y ☐ N ☐ CSS ☐ CRRC ☐ ER Other:

Referred to Regional Service Team clinic:

☐ SCMH ☐ Anderson ☐ Burney Other:

Appt info: Date: Time: Contact name:

Organizational provider referral:

Agency/provider name: Phone: Fax:

Appt info: Date: Time:

Collateral referrals:

☐ Food ☐ Social supports ☐ Housing

☐ Employment ☐ Other

SCMH outpatient assessment appointment on:

Date: Time: PSC: Loc:

Clinician's summary and recommendations:

Clinician signature: Date:

-Youth Only-

Intake package mailed (date):

☐ HX form received ☐ ROI received

☐ Clinic policy letter received Custody docs requested (date): ☐ Received

Print Form

Access Team Triage

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