

1 - Office	4 - Home	8 - Correctional Facility	11 - Faith-based	14 - Client's Job Site	17 - Non-Traditional	20 - Telehealth
2 - Field	5 - School	9 - Inpatient	12 - Health Care	15 - Adult Residential	18 - Other	21 - Unknown
3 - Phone	6 - Satellite Clinic	10 - Homeless	13 - Age-Specific	16 - Mobile Service	19 - Childrens Residential	

DATE: SERVICE TIME: LOCATION: SERVICE TYPE:

ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE"). THE ASSESSMENT SHOULD ILLUSTRATE ALL MEDICAL NECESSITY PRESENT AND PROVIDE THE BASIS FOR THE DSM-4 DIAGNOSIS.

**IDENTIFYING DATA**

NAME:  
 AGE: DOB: GENDER: MARITAL STATUS: EDUCATION (YRS.):  
 FAMILY ADDRESS: PHONE:  
 LIVES IN/WITH:  
 ETHNICITY: LANGUAGE: PRIMARY MD: PHONE:  
 PERSON GIVING CONSENT:  
 REFERRAL SOURCE: OTHER RELATIONSHIP:  
 EMERGENCY CONTACT: ADDRESS: PHONE:

**REFERRAL INFORMATION**

SELPA: IEP DATE REQUESTING SVCS: DATE REFERRAL REC'D:  
 DATE ASSESSMENT PLAN SIGNED: DATE ASSESSMENT COMPLETED:

PRESENTING PROBLEM/HISTORY OF CURRENT PROBLEMS:  
 RECORDS REVIEWED (List all separate mental health episodes, school, and other records reviewed):  
 1.

**SCHOOL RECORDS**

SCHOOL ATTENDING: NPS GRADE LEVEL: 7TH  
 LEVEL OF SPECIAL EDUCATION: nps  
 HISTORY OF SCHOOL INTERVENTIONS:

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**SUMMARY OF INTERVIEWS**

INTERVIEW with PARENT:

CHILD INTERVIEW:

TEACHER INTERVIEW:

**SUMMARY OF TESTING**

No DBH testing at this time.

**PSYCHIATRIC HISTORY**

Sources of Information:

History of Mental Illness in Family:

INPATIENT:

OUTPATIENT MENTAL HEALTH HX:

SUICIDE/HOMICIDE HISTORY:

MEDICATIONS:

Past:

Current:

**MEDICAL HISTORY**

CURRENT HEALTH PROBLEMS: Medical Referral Needed?  Yes  No

SLEEP: ( No problems reported)  Current sleep problem:

APPETITE: ( No problems reported)  Weight Gain  Weight Loss  Current appetite problem

PHYSICAL, DEVELOPMENTAL, COGNITIVE, AND OTHER HANDICAPS:

HEAD INJURIES, UNCONSCIOUSNESS, SEIZURES: ( No history)  Hx of head injuries, unconsciousness, seizures

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**SUBSTANCE ABUSE PROBLEMS**

Nicotine	<input type="checkbox"/> Denied	<input type="checkbox"/> Hx of problem	<input type="checkbox"/> Current problem	_____
Alcohol	<input type="checkbox"/> Denied	<input type="checkbox"/> Hx of problem	<input type="checkbox"/> Current problem	_____
Drugs	<input type="checkbox"/> Denied	<input type="checkbox"/> Hx of problem	<input type="checkbox"/> Current problem	_____
Medication	<input type="checkbox"/> Denied	<input type="checkbox"/> Hx of problem	<input type="checkbox"/> Current problem	_____
Caffeine	<input type="checkbox"/> Denied	<input type="checkbox"/> Hx of problem	<input type="checkbox"/> Current problem	_____
Other	<input type="checkbox"/> Denied	<input type="checkbox"/> Hx of problem	<input type="checkbox"/> Current problem	_____

DEVELOP. HISTORY/ MILESTONES:

**EMPLOYMENT**

<input type="checkbox"/> Full-time employment (as)	_____	<input type="checkbox"/> Part-time employment	_____
<input type="checkbox"/> Job training (to be)	_____	<input type="checkbox"/> Unemployed	_____
<input type="checkbox"/> Disabled (due to)	_____	<input type="checkbox"/> Retired	_____
<input type="checkbox"/> Homemaker	_____	<input type="checkbox"/> F/T Student	_____

CURRENT INCOME/SOURCES

**LEGAL HISTORY**

ARRESTS: (  None reported)

CURRENT LEGAL PROBLEMS (  None reported)

SEXUAL ORIENTATION/CULTURAL/FAMILY/SPIRITUAL ISSUES:

**RISK ASSESSMENT**

CURRENT HEALTH CONDITIONS PLACING CLIENT AT SPECIAL RISK: (  None reported)

ALLERGIES/ADVERSE RXNS TO MEDICATIONS:

RISK FOR ABUSE AND/OR VICTIMIZATION: (  Non-significant)

SUICIDALITY: (  Denied)  Ideation  Intent  Means  Plan  Attempts  Gestures

HOMICIDALITY: (  Denied)  Ideation  Intent  Means  Plan  Attempts  Person at risk:

CLIENT STRENGTHS:

OTHER COMMENTS:

DYSFUNCTION RATING (use DBH definitions):  Less than mild  Mild  Moderate  Severe

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OTHER AGENCIES/PROVIDERS WITH WHOM THE CLIENT IS INVOLVED:

DISPOSITION (List actions taken, recommendations, and referrals made)

**AB2726 ELIGIBILITY SUMMARY**

Service recommendation below is based on the following:

- No mental health services recommended under AB2726 Program.
- Mental health services are recommended, but not under AB2726 Program.
- Client is approved for AB2726 mental health services.
- RECOMMENDED LEVEL OF RESIDENTIAL PLACEMENT (if checked): Residential services will be required to provide the following: therapeutic milieu to develop client's sense of safety and self confidence, specific activities and therapy experiences to promote better interpersonal skills and understanding of his/her emotions (e.g., individual, family, group) participation in a highly structured educational program, supervision by awake staff 24 hours/day to ensure his/her safety, and appropriate staff to intervene to protect client or others from his/her impulsive/aggressive actions.
- CASE MANAGEMENT SERVICES (if checked): to be provided at least monthly to ensure delivery of mental health services and to monitor client's progress.

SUMMARY OF TARGET PROBLEMS FOR AMELIORATION: (Correlate with MHS Service Plan)

1. Provide services to reunify the family.
2. Improve social functioning.
3. Reduce impulsive actions.

Client  does  does not (check one) have Adoption Assistance funding available for residential placement.

Client  does  does not (check one) have a history of clinically significant firesetting. (If client has clinically significant firesetting, please complete and attach *Clinical Assessment Addendum - Firesetting*)

Client  does  does not (check one) have a history of clinically significant assaultive behavior. (If client has clinically significant assaultive behavior, please complete and attach "Clinical Assessment Addendum - Assaultive Behavior")

**RECOMMENDATIONS**

- I. Therapeutic Services to be provided by:  San Bernardino DBH Contract Clinic  Contractor (group home)  
It is recommended that client continue to receive outpatient counseling services until he enters a voluntary out-of-home placement.
- II. Type of services to be provided:  individual  group  family  Other, specify:

SIGNATURE \_\_\_\_\_ PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_

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