SAN BERNARDINO COUNTY | **Department of Behavioral Health**

Specialty Crisis Progress Note

Demographic Information

Client Name:	Client ID:
Practitioner:	Service Program:
Service Charge Code:	Date of Service:
Location:	Face to Face (Minutes):
Documentation Time:	Travel Time:

Interpreter: ☐ Yes ☐ No   Name of Interpreter:

Emergency Indicator: ☐Yes ☐No

Progress Note Entry For:	Note Type:
☐ Existing Service ☐ Existing Appointment ☐ Independent Note ☐ New Service	☐ CCRT ☐ TEST

Clinical Information

Crisis Intervention / Presenting Problem:

Observations:

Client's Report of Incident/Events:

Collateral's Report of Incident/Events:

Purpose of Service

☐ To assess client to determine if client meets criteria for involuntary   hold for danger to self/others or gravely
   disabled (5150/5585)

☐ Other: [   ]

Conservatorship

Conservatorship: ☐ Yes ☐ No

Name of Conservator:	Phone Number:

Reason for Referral

☐ Danger to Self
☐ Danger to Others
☐ Gravely Disabled
☐ Other

Developmental History (Children Only)

Suicide

If current suicide risk is present complete the appropriate Columbia Risk Assessment.

Suicide: ☐ Yes ☐ No

Current Suicide Risk Explanation:

Suicide Risk History:

Current Homicide Risk:
☐ Ideation   ☐ Attempt
☐ Plans   ☐ Means
☐ History (Previous Attempt/Previous 5150/5585)   ☐ None Reported

Current Homicide Risk Explanation:

Current Stressors:
☐ Family   ☐ Recent Losses
☐ Boyfriend/Girlfriend   ☐ Anniversary Date
☐ Community   ☐ Danger of Losing Housing
☐ Physical/Sexual Abuse   ☐ School
☐ Work   ☐ Other:
☐ Medical

Current Stressors Explanation:

History of Relevant Stressors:

Other Explanation:

Problems in Community Functioning:

☐ Housing   ☐ School

☐ Work   ☐ Community

☐ Financial   ☐ Self-Care

☐ Legal   ☐ Social Relationships

☐ Employment   ☐ Other

Other:

Family/Client Strengths:

☐ Extended Family   ☐ Faith Community

☐ Friends   ☐ Other

Other Explanation:

Past Mental Health Treatment:

Psychotropic Medications Current and Past:

Current Health Conditions placing clients at special risk (as reported by the client):

Medication/Prescription History

Current Prescriptions/Herbal Medications: ☐ Yes ☐ No

Please List:

Current Substance Use:

☐Yes ☐No

☐ Alcohol
☐ Cannabis
☐ Opioids
☐ Other Psychoactive substance
☐ Inhalants
☐ Hallucinogens
☐ Sedatives, Hypnotics, Anxiolytics
☐ Cocaine
☐ Other Stimulants

Legal Problems Related to Substance Use:
☐Yes ☐No
If yes, please explain:

Substance Use Disorder Treatment:
☐Yes ☐No
If yes, please explain:

Past Substance Use Disorder Treatment:
☐Yes ☐No
If yes, please explain:

Describe (for current or past use) type, frequency, quantity, last use, age of first use and family history:

Probation Parole Information

Are you on Probation?	☐ Yes	☐ No	Probation Officer Name:	Phone:
Are you on Parole?	☐ Yes	☐ No	Parole Officer Name:	Phone:

Abuse History

Abuse History (If none reported, please put N/A in the **explanation** field):

☐ Physical   ☐ Sexual
☐ Domestic Violence   ☐ None Reported

Explanation:

Disposition

Intervention (Include specifics of safety planning):

Client Response:

Collateral Information: ☐ Yes ☐ No

If yes, please explain:

Plan for Subsequent Service/Follow Up:

Disposition:

☐ 5150/5155
☐ Voluntary
☐ Hospitalization Diverted
☐ Referral and Linkage

Transport:

☐ Self
☐ Caretaker
☐ County Care Manager

☐ Family
☐ Conservator
☐ N/A

Hand-Off to:
☐ Self
☐ ARMC BH Triage
☐ Caretaker
☐ CRT
☐ Conservative
☐ Other

☐ Family
☐ ARMC ER
☐ Law Enforcement
☐ CSU
☐ N/A

Agency Completing Hold:

☐ Hospital
☐ Law Enforcement Agency
☐ CCRT
☐ Other DBH

Time hold written: _____
Date hold written: _____

Name of Person completing hold: _____

Accepting Hospital:

☐ Aurora Charter Oak
☐ Canyon Ridge Hospital
☐ San Bernardino Community Hospital
☐ Loma Linda BMC
☐ Loma Linda ER
☐ Redlands Community

☐ VA
☐ ARMC BHU
☐ Pacific Grove
☐ Unknown-Other Agency Transported
☐ Other
    Please provide name of hospital: _____

Hospital Sit Duration: _____

Transportation to Hospital (who took client):

☐ Family
☐ Law enforcement
☐ Ambulance
☐ Other
If other, please explain:

_____

☐ CWIC
☐ TEST
☐ CCRT

Transport Duration: _____

Client Linkages: _____

Consultation Information

Consultation with Supervisor On Call (SOC): ☐ Yes   ☐ No

Name of SOC, Explain if no SOC:

_____

Consent Status (Adults Only)

☐ Client available to sign consent/HIPAA forms, Advanced Directive
☐ Client signed an Authorization to Release Information (ROI)
☐ Client unable to sign consents (follow up letter sent to client)
☐ Unwilling/Refused to sign consents

☐ Conservator/Office of the Public Guardian available to sign consent/HIPAA forms.
☐ Conservator/Office of the Public Guardian contacted via 24-hour hotline and verbal consent obtained (appropriate forms faxed).
☐ N/A

Consent Status (Children Only)

☐ Parent/Guardian available to sign consent/HIPAA forms, Caregiver's Authorization Affidavit signed where appropriate.

☐ Child was evaluated at location other than home. Verbal consent given by parent/guardian due to a medical emergency. Written consent will be obtained, as soon as feasible, to ensure proper documentation.

☐ Child was evaluated at location other than home. The parent/guardian could not be contacted for consent. Treatment was provided due to a medical emergency. Written consent will be obtained, as soon as feasible, to ensure proper documentation.

☐ Child is a dependent of CFS or Probation, will contact worker to request written consent.

☐ Other consent status.

☐ N/A

Provider Consent

Screener Name:	Title:
Signature:	Date:
Telephone Number:	Fax:

Licensed Mental Health Provider Consent (if required)

Provider Name:	Title:
Signature:	Date: