**County of San Diego Mental Health Services**

**MOBILE CRISIS ASSESSMENT**

**Client Name:       Case #:**       **Assessment Date:**

**Program:       \*Unit:       \*SubUnit:**

Type of Contact: [ ]  Telephone [ ]  Face-to-Face [ ]  Telehealth

**Unique Referral Number**:

Does client meet criteria for continued services: [ ]  Yes [ ]  No [ ]  Declined Services

If declined services, why: (Choose an item.)

 If Other, explain:

If No or refused; explain rationale as to why client did not meet criteria (Does not meet medical necessity, does not meet level of referral, client is currently physically injured, client has a weapon, there is a current medical emergency, if there an active crime occurring, client is actively violent, and other potential reasons):

If criteria were not met due to a need to contact EMS or Law Enforcement, was coordination provided promptly? [ ]  Yes [ ]  No; If no, explain:

**Reason(s) for Referral (check all that apply):**

**[ ]** Suicidal Ideation [ ]  Grave Disability [ ]  Symptoms of Psychosis

[ ]  Substance Use [ ]  Mood-dysregulation [ ]  Homicidal Ideation

[ ]  Danger to Self [ ]  Danger to Others [ ]  Other

If other, explain :

Is the client under 18? [ ]  Yes [ ]  No

Is client on Conservatorship? [ ]  Yes [ ]  No [ ]  Unable to Assess

Does client have Regional Center involvement? [ ]  Yes [ ]  No [ ]  Unable to Assess

Does client have CWS involvement? [ ]  Yes [ ]  No [ ]  Unable to Assess

**\*PRESENTING PROBLEM:** *(A summary of your clinical assessment. It should include: how you became involved with client, scene overview, client report, 3rd party report, justify 5150 or lack thereof. Name/age/ethnicity/gender/language spoken/living situation/circumstances for the referral/precipitating event(s)/current symptoms and behaviors (intensity, duration, onset, frequency) impairments in life functioning caused by the symptoms/brief description of current treatment/organizations, or groups involved/strengths/support):*

\*This contact is related to which of the following:

[ ]  Mental Health [ ]  Substance Use [ ]  Co-Occurring

\*Is client currently taking medications (prescribed or over the counter): [ ] Yes [ ] No [ ]  Unknown

List Medications:

\*Is client receiving treatment for any medical conditions: [ ] Yes [ ] No [ ]  Unknown

Describe *(include consideration of co-morbid disabilities, intellectual and/or developmental disabilities (I/DD), traumatic brain injury (TBI))*:

\*Does the client have a Primary Care Physician: [ ] Yes [ ] No [ ]  Unknown

If no, has client been advised to seek primary care: [ ] Yes [ ] No

Primary Care Physician:       Phone Number:

\*Does client identify as a member of a tribal community?

[ ]  Yes [ ]  No [ ]  Refuse/Cannot Assess

If YES , has the client seen an Indian Health Care Provider (IHCP) in the previous 12 months or have a preference to receive follow up care from an IHCP?

[ ] Yes [ ] No [ ]  Unknown/Refused

\* Has client received any behavioral health treatment within the last 12 months? If Yes selected, provide treatment history below.

[ ]  Yes [ ]  No [ ] Unknown

\*Current and Past Behavioral Health Treatment *(Describe recent hospitalizations, any connections with current MH providers, relevant past psychiatric/SUD history):*

Insurance? [ ] Yes [ ] No [ ]  Unknown [ ]

(If Yes, check all that apply)

 [ ] [ ]  Medi-Cal

 [ ] [ ]  Medicare

 [ ] [ ]  Private Insurance/ VA/ Tricare

If client has private insurance, do they have a current behavioral health provider outside the MHP?

[ ]  Yes [ ]  No [ ]  Unable to Assess

Outside Provider information, if available:

**SCHOOL INFORMATION:** *(if responses to \*questions are “No”, client not currently in school or not of school age, answers required only as clinically relevant)*

\*Is the contact location on a school/college/university site?

[ ]  Yes [ ]  No [ ]  Refused/Unable to Assess

\*Is client currently in school? *(select “Yes” if enrolled but on school break)*

[ ]  Yes [ ]  No [ ]  Refused/Unable to Assess

Current School:

If Other:

Current Grade Level:

Does client have an IEP or 504 Plan? [ ]  Yes [ ]  No [ ]  Unable to Assess

Educationally Related Mental Health Services? [ ]  Yes [ ]  No [ ]  Unable to Assess

History of behavioral problems in school? [ ]  Yes [ ]  No [ ]  Unable to Assess

Does client have a history of truancy, [ ]  Yes [ ]  No [ ]  Unable to Assess

suspensions or expulsions?

School violence plan? [ ]  Yes [ ]  No [ ]  Unable to Assess

If any yes answers, describe:

**SOCIAL CONCERNS**: *(responses required as clinically relevant)*

Peer/Social Support [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Substance use by peers [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Gang affiliations [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Family/community support system [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Religious/ spirituality? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

LGBTQ+ identification/engagement [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Justice system [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

History of bullying? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess History of being bullied? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess Victim of violence/abuse? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Has a preoccupation with violence? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess Violent drawings/writings? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess Media research on explosives, weapons,

terrorist sites, school shootings? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Has intended victims? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Stalking behavior? [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**POTENTIAL FOR HARM/RISK ASSESSMENT**

\*Current Suicidal Ideation? [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Specify plan intent and/or ability to carry out the plan:

\*Previous attempts or past suicidal behaviors?

[ ]  within past 12 months [ ]  greater than 12 months [ ]  None [ ]  Unknown/Refused

\*Describe:

\*Are the client’s current/recent behaviors possibly creating a danger to self *(things to consider: non-suicidal self-injurious behavior, method, severity, frequency, remote vs ongoing)?*

[ ]  Yes [ ]  No [ ] Unknown/Refused

\*Explain:

\*Access to weapons/explosives? [ ]  Yes [ ]  No [ ] Unknown/Refused

\*Current Homicidal Ideation Towards Others? [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Specify if plan, intent and/or ability to carry out the plan:

\*Previous homicidal ideation towards others?

 [ ]  within past 12 months [ ]  greater than 12 months [ ]  None [ ]  Unknown/Refused

\*Explain:

\*Does the client have past behavior of violence *(Things to consider: toward property or animals, toward people, domestic violence, anti-social, intimidation, predatory, restraining orders?*)

[ ]  within past 12 months [ ]  greater than 12 months [ ]  None [ ]  Unknown/Refused

\*Describe:

\*Identified Victim(s)? [ ]  No [ ]  Yes \*Tarasoff Warning Indicated? [ ]  No [ ]  Yes

Reported To:       Date:

\*Were there multiple victims identified? [ ]  Yes [ ]  No

\*Victim(s) name and contact information *(Give victim information, time/date, and method of notifying the victim. Provide the Tarasoff warning details):*

\*Is the client’s current/recent behavior possibly creating a danger to others?

[ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Describe:

\*Gravely Disabled? [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*If yes, describe *(Explain why client did or did not meet criteria. Be very specific and clear. Gravely disabled is the inability to procure and/or utilize food, clothing, and/or shelter):*

\*Current Abuse or Domestic Violence: [ ]  No [ ]  Yes [ ]  Unknown/Refused to answer

\*If yes, describe situation (*identify parties involved, current restraining or protective order in place, etc)*:

\*Child/Adult Protective Services Notification Indicated? [ ]  Yes [ ]  No

\*History of Trauma? [ ]  Yes [ ]  No [ ]  Unknown/Refused to answer

\*Describe:

\*Recent Substance Use? [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*If Yes, Describe:

\*History of substance use or treatment for substance use? [ ]  No [ ]  Yes [ ]  Unknown/Refused

\*If Yes, Describe:

\*Describe Factors Increasing Risk *(What are the barriers to client being successful in the community: Why is MCRT/PERT being utilized?)*:

**OUTCOME/ DISPOSITION**

Safety Plan: Including Plan, Details of Safety Plan:

Describe Protective Factors/Strengths: *(strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others; include consideration of cultural factors including but not limited to tribal community engagement, LGBTQ+ identification, and deaf/hard of hearing community engagement)*:

\*Describe Outcome of Encounter*:(What criteria did the client meet? Referrals offered? Include (if client refused the referrals. Tarasoff details)*:

**CARE COORDINATION:**

Which of the following providers were contacted by the Clinician? *(check all that apply):*

**[ ]** Outpatient Treatment Provider [ ]  Psychiatrist [ ]  School Representative

[ ]  Probation Officer [ ]  CWS Worker [ ]  APS worker

[ ]  LECC/Other LE agencies [ ]  Conservator’s Office [ ]  Residential Treatment Provider [ ]  Other [ ]  Not Applicable [ ]  Regional Center

[ ]  Indian Health Care Provider (IHCP)

For any item indicated, provide documentation as to the nature of the contact or why not applicable:

**Signature of Staff Completing Assessment:**

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

Signature Date Time

Printed Name:       CCBH ID number: