**County of San Diego Mental Health Services**

**PERT INITIAL SCREENING**

**\*Client Name:** **\*Case #:**

**\*Initial Screening Date:**       **\*Program Name:**

\*Type of Contact:  Telephone  Face-to-Face

Informant Name:

Relation to Client *(Select from Relationship Table located in the Instruction Sheet)*:

\*Is the client under 18?  Yes  No Client’s Age Today:       Date of Birth:

\*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

Region service provided in:  Central  North Central  East

South  North Inland  North Coastal

**\*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):*

This PERT 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

Current and History of Mental Health Treatment *(check all boxes that apply)*:  Outpatient  Inpatient  Psychiatric Medications

**SCHOOL INFORMATION:**

Is client currently in school?  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?

History of bullying?  Yes  No  Unable to Assess

History of being bullied?  Yes  No  Unable to Assess

Victim of violence/abuse?  Yes  No  Unable to Assess

Has a preoccupation with violence?  Yes  No  Unable to Assess

Violent drawings/writings?  Yes  No  Unable to Assess

Media research on explosives, weapons,

terrorist sites, school shootings?  Yes  No  Unable to Assess

Has intended victims?  Yes  No  Unable to Assess

Stalking behavior?  Yes  No  Unable to Assess

School violence plan?  Yes  No  Unable to Assess

If any yes answers above explain:

**POTENTIAL FOR HARM/RISK ASSESSMENT TAB**

\*Current Suicidal Ideation?  Yes  No Unknown/Refused

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

\*Previous Attempts or past suicidal behaviors?  Yes  No Unknown/Refused

\*Describe:

\*Has the client had suicidal ideation in the past 12 months?  Yes  No

Unknown/Refused

\*Explain:

\*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 Violent/Homicidal Ideation Towards Others?  Yes  No Unknown/Refused

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

\*Has the client had violent/homicidal ideation towards others in the past 12 months?

Yes  No 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?

Yes  No Unknown/Refused

\*Describe:

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

Reported To:       Date:

\*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 to answer

*(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 due to mental illness).*

\*Describe:

\*Current Abuse or Domestic Violence:  Yes  No Unknown/Refused

\*Describe situation:

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

Reported to:       Date:

\*Recent Substance Use?  No  Yes  Unknown/Refused to answer

\*Describe:

\*History of substance use or treatment for substance use?  No  Yes  Unknown/Refused to answer

\*Describe:

\*Justice System Involvement? *(Add details when you have them. Avoid using police codes: ex 290, 245, etc.)*

Yes  No Unknown

If yes, describe recent arrests, probation, sex offender information, et:

**OUTCOME/DISPOSITION TAB**

\*Insurance:  No  Yes

(If Yes, check all that apply)

Medi-Cal

Medi-Care

Private Insurance/VA/Tricare

Describe Factors Increasing Risk (What are the barriers to client being successful in the community, why is PERT being utilized?):

Describe Protective Factors:

Safety Plan:

Disposition Level:

Emergency

Urgent

Non-Urgent

Emergency = 5150, voluntary hospitalization

Urgent = Transports to crisis residentials (includes withdrawal management, etc.), urgent walk-in centers or MH or SUD outpatient clinics

Non-Urgent = Review of protective factors & BHS resources, linkage

\*Referred to: *Check all that apply*

ACL, 211. Or Other Community Support  Act Program  ADS  CAC  CAPS  Case Management Program  Clubhouse  CSU  ESU  FFS Hospital  FFS Individual Provider  FQHC  Hospital/ER  Jail  Juvenile Hall  Managed Care Plan – MH Provider  Managed Care Plan – PCP  Mental Health Res Treatment Facility  No Referral  OP Clinic  Other  Other Community Services  PEI Program  Regional Center Services  SDCPH  Specialty Mental Health Services  START (Crisis House)  Substance Abuse Treatment - OP  Substance Abuse Treatment – Residential  TBS  WIAC/JWC  Withdrawal Management

If Other, specify:

Referrals:

Name

Address

City/State/ZIP

Phone

Person to Contact

Directions or Other Instructions

Referrals:

Name

Address

City/State/ZIP

Phone

Person to Contact

Directions or Other Instructions

Referrals:

Name

Address

City/State/ZIP

Phone

Person to Contact

Directions or Other Instructions

Describe Outcome, Including Plan *(What criteria did the client meet? Referrals offered, include if client refused the referrals. Tarasoff details)*:

**CARE COORDINATION:**

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

Outpatient Treatment Provider  Psychiatrist  School Representative

Probation Officer  CWS Worker  APS worker  Regional Center

LECC/Other LE agencies  Conservator’s Office  Other

Not Applicable

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

**Signature of Staff Completing Screening:**

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

Signature Date Time

Printed Name:       CCBH ID number: