**(Due to Optum TERM within 14 calendar days of the initial authorization start date)**

**I received and reviewed the following records provided by the SW (required prior to the intake assessment):**

**[ ]** Detention Hearing Report

**[ ]** Jurisdiction/Disposition Report

**[ ]** Copies of significant additional court reports

**[ ]** Copies of all prior psychological evaluations and Treatment Plans for the client

**[ ]** All prior mental health and other pertinent records

**[ ]** Copies of History & Physical and Discharge Summary written by psychiatrist

**[ ]** For Voluntary Services cases: Summary of case information and protective issues

|  |  |  |  |
| --- | --- | --- | --- |
| Facilitator: |       | Phone:       | Agency:       |
| SW Name: |       | SW Phone:       | SW Fax:       |
| Date of Intake: |       |
| **DEMOGRAPHIC INFORMATION**The client is Choose an item. and self-identifies as Choose an item. . The client’s preferred language is Choose an item..Client states that the reason for referral to treatment is [brief description reflecting client’s understanding of CWS involvement and reason for referral to IPV services]:      . This case is currently Choose an item..Client and/or family have immigrated to the United States to escape war, persecution, or poverty [ ]  Yes [ ]  No If “Yes”, describe how immigration history and/or cultural/identity factors may have influenced client’s understanding of the protective issues or willingness to collaborate with CWS:        |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mental Status/Psychiatric Symptom Checklist:**The following *current* symptoms were reported and observed:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Angry mood | [ ]  Dissociative reactions | [ ]  Fatigue | [ ]  Isolation |
| [ ]  Anhedonia | [ ]  Distorted blame | [ ]  Flashbacks | [ ]  Memory challenges |
| [ ]  Anxious mood | [ ]  Distress and/or physiological reactions to trauma reminders | [ ]  Helplessness | [ ]  Psychomotor agitation |
| [ ]  Appetite disturbance | [ ]  Distressing dreams | [ ]  Homicidality | [ ]  Sleep disturbance |
| [ ]  Avoidance | [ ]  Euphoric mood | [ ]  Hopelessness | [ ]  Somatic complaints |
| [ ]  Concentration challenges | [ ]  Euthymic mood | [ ]  Hypervigilance | [ ]  Suicidality |
| [ ]  Depressive mood | [ ]  Exaggerated startle response | [ ]  Intrusive memories | [ ]  Other:       |
| [ ]  Derealization | [ ]  Fatalistic cognitions | [ ]  Irritable mood |  |

 |
| **Screening Tool Results (indicate name and results of all tests administered):**

|  |  |
| --- | --- |
| Substance Abuse Screening Tool Administered (*Required)*:       | Results:       |
| Danger Assessment Tool (*Campbell, 2019*) (*Required):*       | Results:       |
| Other Screening Tool Administered:       | Results:       |
| Other Screening Tool Administered:       | Results:       |

 |
| **Strengths and Barriers** (indicate client’s readiness to change, barriers to engage in treatment, and strengths):      **Level of commitment** to attend, participate and change through the treatment program:     .[ ]  Client is appropriate for Domestic Violence Victim group treatment Additional suggestions to SW for adjunctive treatment while client is in Domestic Violence Victim group treatment (if applicable)**:**        |
| [ ]  Client is **not** appropriate for Domestic Violence Victim group treatment (client to be discharged)Reason/s client is not appropriate for group at this time: 1. [ ]  Actively abusing drugs & alcohol; chemical dependency treatment is to precede treatment for child abuse
2. [ ]  Serious emotional disturbance, requires appropriate psychiatric and medical care to be addressed prior to group involvement
3. [ ]  Unable to tolerate involvement in a group (e.g., due to personality characteristics
4. [ ]  Other (describe):

Recommended alternative treatment:      Additional information referring party should know, including additional clinical concerns that require adjunctive treatment:      Date SW Notified:       |
| **DIAGNOSIS:**List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. The Primary Diagnosis should be listed first.

|  |  |  |  |
| --- | --- | --- | --- |
| **ID (ICD-10)** | **Description** | **Corresponding DSM-5-TR Diagnostic Code or V Code** | **Corresponding DSM-5-TR Diagnostic Description or V Code Description** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |

**Comments** (Document criteria met for diagnosis, any diagnostic rule outs, reason for diagnostic changes and any other significant information):      |

**GOALS TO ADDRESS IN TREATMENT**

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| --- |
| 1. Client is able to develop a written safety plan to protect self and child(ren) from IPV, including warning signs of abusive behaviors, identification of safety network, and action steps to implement safety planning strategies.
2. Client is able to demonstrate understanding of the cycle of violence, types of abuse, role played in IPV dynamics.
3. Client is able to demonstrate effects of IPV on child(ren)/parenting and identify effects on their children.
4. Client is able to demonstrate the actions of protection over time in role as a parent.
5. Client is able to demonstrate understanding of healthy/safe relationships and impact on child development

**Additional Treatment Goals (if indicated for this client):**1. Other:
2. Other:
 |

**SIGNATURE**

|  |  |
| --- | --- |
| Provider Signature:       | License/Registration #:        |
| Print Name:       | Signature Date:       |
| Provider Phone Number:       | Provider Fax Number:       |
| ***Required for Interns Only*** |
| Supervisor Printed Name:       | License type and #:       |
| Supervisor Signature:       | Date:       |

Submit Group Progress Report Forms quarterly to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved Intake Assessment to the SW.

Date faxed to **Optum TERM at: 1-877-624-8376**: