People Inc.
Screening for Youth & Family Services

Date: ____/____/____ Time of Call: _________am/pm Staff taking call: __________

Who is providing information for this referral and their relation to the individual?:

______________________________________ ___________________________

Name Relation

Is the individual 18 years old or an emancipated juvenile? ☐ **Yes** ☐ **No**

If no, who has legal guardianship of individual? (Legal guardian or custodian will be required to present documentation of legal guardianship.)

______________________________________ ____________________________

Parent/Guardian Relation

Are there any confidentiality issues? ☐ **Yes** ☐ **No**

If yes, please explain: ____

INDIVIDUAL IN NEED OF SERVICES

Name: (first/last) _____________________________________ **Gender:** ☐ **M** ☐ **F**

Address: ____

City: _____________________________________ **Zip:** ____________________

Phone: ______________________

Date Of Birth: ____/_____/_____ Age: _______________ **SS#:** _______-______-_______

Race: (Check all that apply)

☐ **American Indian** ☐ **Black/African American** ☐ **Asian** ☐ **Native Hawaiian/Pacific Islander**

☐ **White** ☐ **Hispanic/Latino** ☐ **Other:** ____

Is the individual currently receiving services? ☐ **Yes** ☐ **No**

If yes, where? ____

Does the individual have insurance? ☐ **Yes** ☐ **No**

If yes, please indicate below:

☐ **Private** ☐ **Medicaid** ☐ **Medicare** ☐ **Private Pay** ☐ **Other:** __________ **ID#:** ___________

If uninsured does individual/family need assistance filing for Medicaid? ☐ **Yes** ☐ **No**

If yes, was information provided/or call made to community resource? ☐ **Yes** ☐ **No**

REASON FOR REFERRAL

Why does the individual need to be seen? (Please include immediate/urgent needs including but not limited to medical, crisis stabilization, risk taking behaviors, and current thoughts of harming self and/or others) ____

____

____

EMERGENCY CONTACT

Is there someone to contact in case of emergency?

Name: ________________________________ **Phone:** _______________________________

Address: _______________________________ **Relationship:** __________________________

Disposition (for staff only):

☐ Referred for Assessment: Date: _____/_____/______ Clinician: ___________________________

☐ Consumer was informed regarding reasons for ineligibility: ☐ In Person ☐ By Phone ☐ In Writing

☐ Referral Source contacted (w/written consent) regarding reasons for ineligibility ☐ Yes ☐ No ☐ N/A

☐ Referral to Community Resources ☐ Yes ☐ No ☐ N/A Specify: _________________________

☐ Other Pertinent Info: ____

Consumer Name: __________________________ ID#: _____________________

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Mental Health

Within the last 90 days (3 months) have you had a significant period in which you have experienced:

Serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Serious anxiety or tension (felt uptight, worried, unable to relax)?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Being prescribed medication for psychological/emotional problem?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Thoughts of harming yourself?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Hallucinations (heard/seen things others don't hear or see)?	☐ **Yes**	☐ **No**	☐ **Not Provided**
An Attempted suicide?	☐ **Yes**	☐ **No**	☐ **Not Provided**

Substance Abuse

During the past 12 months have you:

Been preoccupied with drinking alcohol and/or using other drugs?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Tried to stop drinking alcohol and/or using other drugs, but couldn't?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Had problems caused by drinking/using drugs, and you kept using?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Drunk alcohol and/or used other drugs more than you intended?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Experienced periods of time where your thinking speeds up and you have trouble keeping up with your thoughts?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Drunk alcohol and/or used other drugs to alter the way you feel?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Need to drink and/or use more to get the same effect you used to?	☐ **Yes**	☐ **No**	☐ **Not Provided**

Trauma

During the past year (12 months) have you:

Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Had periods of time where you felt that you could not trust family or friends?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Ever been afraid of your partner and/or a family member?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened?	☐ **Yes**	☐ **No**	☐ **Not Provided**

Gambling

During the past year (12 months) have you:

Felt the need to bet more and more money?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Had to lie to people important to you about how much you gamble?	☐ **Yes**	☐ **No**	☐ **Not Provided**

Child/Adolescent Section

Are you feeling mad, sad, hopeless, nervous, or have you had a change in your sleeping, eating or school performance?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Are you spending less time with friends, care less about your appearance, or feel alone?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Get into trouble for acting up, fighting, setting fires, hurting animals or tearing up stuff?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Have you ever experienced a very bad thing or person (traumatic event) where you continued to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Are you using alcohol and/or illegal drugs including inhalants?	☐ **Yes**	☐ **No**	☐ **Not Provided**
Are you misusing any prescription medication or over the counter	☐ **Yes**	☐ **No**	☐ **Not Provided**

Consumer Name: ______________________________ ID#: ________________________