Screening Summary Form (DPS)

Section I: Youth Information

Youth ID: ________________   Sex: ❒ Female ❒ Male

Age: ____________________   Grade: ❒ 6th ❒ 7th ❒ 8th ❒ 9th

Date: ____/____/____   ❒ 10th ❒ 11th ❒ 12th ❒ Not in School

Section I: Screening Results & Next Steps

Positive screen if any one of these is checked:

❒ Q. **23** <u>or</u> Q. **24** = **YES** (Suicide Ideation or Suicide Attempt)

❒ Symptom Scales 1, 2, 3, 4 <u>or</u> 5 **present** <u>and</u> Total DPS Impairment Score ≥ **6**

❒ Total DPS Symptom Score ≥ **9**

❒ Symptom Scales 6, 7, <u>or</u> 8 **present**, regardless of impairment

❒ Youth requests / program staff recommends clinical interview

Screen Results/Next Steps:

❒ Positive screen: **Requires** clinical interview

❒ Negative screen: **Does not require** clinical interview

Section II: Debriefing Interview

Ask All Youth:

1. When you were filling out the questionnaire, did any thoughts, ideas, or concerns come up that you would like to talk about? ❒ Yes ❒ No
   Notes:

Ask All DPS NEGATIVE Youth:

2. Would you like to talk to a health specialist about any concerns or difficulties you are having? ❒ Yes ❒ No
   If Yes, screening is **POSITIVE**

*__If Debriefer believes youth with Negative DPS should proceed to Clinical Interview, check POSITIVE Screen on page one and <u>note reasons below</u>:__

<u>For Youth Who Screen **Positive**</u>: Thank you for participating in the TeenScreen Program. We would like you to speak briefly to a health specialist to go over the results of the questionnaire. **Clinician completes Psychosocial Assessment**	<u>For Youth Who Screen **Negative**</u>: Thank you for participating in the TeenScreen Program. You are now free to….(fill in what is planned for rest of period, e.g., go back to class, work on special project, etc). **STOP HERE**

Debriefer's Printed Name:____

Debriefer's Signature:_______________________________ Date:______________

Date: ____________________________

Psychosocial Assessment

Client Information:

Full Name:	Case/Client #:
SS#:	DOB:
Sex:	Race:
Address:	
Phone #:	
School Attending:	Grade:
Special Programs:	Referral Source:

Parent/Guardian Information:

Full Name(s):

Address:

Work Phone(s):

Place(s) of Employment:

Insurance/Medicaid #:

Mental Health Coverage:

Household Members:

Mother (age):	( )	Father (age):	( )
Stepmother (age):	( )	Stepfather (age):	( )
Grandmother (age):	( )	Grandfather (age):	( )
Sister (age):	( )		
Brother (age):	( )		
Stepsister (age):	( )		
Stepbrother (age):	( )		

Other (relationship/age): (/)
(/)

Reason for Referral:

History of Present Problems:

Psychiatric/Counseling History:

Family Psychiatric and/or Alcohol/Substance Abuse History:

Medical History:

Current Medication(s):

History of seizure activity and the use of anticonvulsants: Yes ( ) No ( ) If *Yes*, specify:

Need for additional health related services: Yes ( ) No ( ) If *Yes*, specify:

Special dietary or Nutritional Needs: Yes ( ) No ( ) If *Yes*, specify:

Family History:

Parent's Marital Status: Married ( ) How Long: Separated ( ) How Long: Divorced ( ) How Long:

Never Married ( ) Widowed ( ) How Long:

Father's Name: Age:

Nationality: Level of education: Occupation:

If client's parents are divorced, is father re-married or cohabitating: Y ( ) N ( ) If *Yes,* how long:

Describe relationship with father:

Mother's Name: Age:

Nationality: Level of education: Occupation:

If client's parents are divorced, is mother re-married or cohabitating: Y ( ) N ( ) If *Yes,* how long:

Describe relationship with mother:

Describe relationship(s) with siblings:

Who is child currently residing with and description of relationship(s) with family members living in the home:

Describe disciplinary methods:

Significant Family Medical Conditions/Illnesses:

Religious Affiliation:

School and Social History:

Place of Birth:

Has there been excessive re-locations (more than 3): Y ( ) N ( )

If *Yes,* briefly give chronological account of location and length of time in each location:

Current School: Current Grade:

Prior Schools:

Academic performance: Excellent ( ) Satisfactory ( ) Unsatisfactory ( ) If *Unsatisfactory,* describe in detail:

History of repeating grade(s): Y ( ) N ( ) If *Yes,* specify:

History of Learning Disabilities or placement in Special Education classes: Y ( ) N ( ) If *Yes,* specify:

History of school behavioral problems or truancy: Y ( ) N ( ) If *Yes,* specify:

Need for Educational or Vocational Referrals: Y( ) N( ) If *Yes*, specify:

Need for independent living and daily living skill development: Y ( ) N ( ) If *Yes*, specify**:**

Involvement in leisure activities or aptitudes:

Describe relationships with peers:

If appropriate, describe dating behavior/relationships**:**

Is client sexually active: Not applicable ( ) Y ( ) N ( ) If *Yes,* note age of first consensual experience**:**

Does client practice safe sex: Not applicable ( ) Y ( ) N ( ) If *No,* specify reasoning**:**

Is client aware of risk regarding Sexually Transmitted Diseases: Not applicable ( ) Y ( ) N ( )

Is there a history of sexual abuse/assault: Not applicable ( ) Y ( ) N ( ) If *Yes,* note date and name/relation of alleged perpetrator(s):

If applicable, did client receive counseling at time of abuse/assault: Y ( ) N ( ) If *Yes*, Where:

Legal History:

Has the client ever been arrested (felonies and/or misdemeanors): Y ( ) N ( ) If *Yes,* specify all charges/dates:

Charge: Date:

Has the client ever been incarcerated: Y( ) N ( ) If *Yes,* specify each charge and length of each incarceration:

Charge: Length**:**

Has the client ever been referred for abuse or neglect: Yes ( ) No ( ) If *Yes,* specify type of referral and outcome:

Type of Referral: Outcome:

Has there ever been a reported history of domestic violence: Yes ( ) No ( ) If *Yes*, give details:

Drug/Alcohol History:

Is the client currently using or under the influence of alcohol or drugs: Yes ( ) No ( ) If *Yes*, give details:

Has client used any of the following three or more times in the last 30 days:

Substance	***Yes***	***No***	***Age of First Use***
Tobacco/Tobacco products			
Beer/Wine			
Hard Liquor			
Inhalants (glue, paint, rush, gasoline, etc.)			
Over the Counter Drugs (over recommended dose)			
Marijuana/Hashish			
Cocaine			
Crack			
Steroids			
Depressants (valium, Quaaludes, etc.)			
Stimulants (uppers, speed, ice, etc.)			
Narcotics (heroin/smack, codeine, morphine, etc.)			
Other (prescription medication, designer drugs)			

Suicide Risk Assessment:

Does client currently experience or does client regularly experience any of the following (ask about duration, persistence and severity of symptoms):

Low Mood:	Guilt / Worthlessness:
Irritability:	Hopelessness:
Lack of pleasure / Interest:	Fatigue / Loss of energy:
Sleep Disturbance:	Decreased concentration / Indecisiveness:
Appetite / Weight change:	Agitation / Retardation:

Suicidal Ideation:

Thoughts of killing self:	Onset, frequency, recency:
Suicide plan / Methods associated with thoughts:	Strength of intent / Wish to die:
Precipitants/ Triggers of suicidal ideation:	Deterrents to suicidal actions:
Thoughts of death (e.g., wish were dead, never wake up):	Onset, frequency, recency:

Suicidal Behavior:

Number of attempts / self-injurious acts in Lifetime: ______

Most RECENT Suicide Attempt	Most SERIOUS Suicide Attempt
Date:	Date:
Method: Planned / Impulsive: Certainty action would result in death (Intent): Disclosure / Discovery / Stopped self: Lethality / Medical attention: Stressors / Mood just prior to attempt: Substance use just prior to attempt:	Method: Planned / Impulsive: Certainty action would result in death (Intent): Disclosure / Discovery / Stopped self: Lethality / Medical attention: Stressors / Mood just prior to attempt: Substance use just prior to attempt:

Summary of Suicide Risk Assessment:

Notes on DPS Positives & Other Problem Areas:

Diagnostic Impressions:

Currently seeing a mental health professional? ❒ Yes ❒ No Future appt. scheduled? ❒ Yes ❒ No

If yes, for what?

Referral Recommended**:** ❒ Yes ❒ No Emergency/Crisis: ❒ Yes ❒ No

Reasons for Referral or Non-Referral:

Youth's Response to Referral**:** ❒ Accepted ❒ Denied ❒ Undecided ❒ Already In Treatment ❒ N/A

Clinician's Printed Name: ____

Clinician's Signature:____ Date: ________________

Supervisor's Signature:____ Date:________________

Case Management & Follow-up:

Date of Initial Contact with Youth:__ __/ __ __ / __ __ Date of Initial Contact with Parent:__ __/ __ __ / __ __

Parent's Response to Referral: ❒ Accepted ❒ Denied ❒ Undecided ❒ Youth Already In Treatment

Initial Appointment Scheduled? ❒ Yes ❒ No Date Scheduled: __ __/ __ __ / __ __

Youth Kept At Least One Appointment? ❒ Yes ❒ No Date First Seen: __ __/ __ __ / __ __

Initial Treatment Provider:

Services Received *Check all that apply:*

❒ School-Based Services
❒ Private Outpatient Care
❒ Emergency Room
❒ Partial Hospital Program
❒ Inpatient Unit
❒ Community Mental Health Center (CMHC) Outpatient Services
❒ Intensive Outpatient Program (IOP)
❒ Mobile Crisis
❒ Hospital-Based Psychiatric Clinic (outpatient)
❒ Other – Specify: ____________________________________

Date Case Closed: __ __/ __ __ / __ __ Date Closing Letter Sent to Parents: __ __/ __ __ / __ __

Reason for Closure:

Additional Case Management Notes:

Case Manager's Printed Name: ____

Case Manager's Signature: ____ Date: _____________