St. Clair County Community Mental Health

Mental Health Services Emergency Pre-Admission Screening

Call Region 10 Access Center for Medicaid or Non-Insured St. Clair County Authorizations at 1-888-225-4447

Date:_____ Individual:_____ Case #: _____

Time of Request:_____ Start Time: _____ Stop Time: _____

Place of Service: _____ Disposition: _____

Guardian Name: _____ Date of Birth: _____ SSN: _____

Address/Phone if not on Hospital Face Sheet _____

Current mental health treatment? ☐Yes ☐ No Medicaid Only or No Insurance: ☐ Yes ☐ No If yes, who and last seen?

Who: _____ Last Seen: _____

Medications: _____

_____

_____

Are you taking them as prescribed? ☐Yes ☐ No Prescriber: _____

Medical Conditions: _____

Presenting Problem: _____

_____

_____

_____

_____

_____

Suicidal Thoughts

Do you engage in self-harm? ..... ☐ Yes ☐No

Do you have thoughts of suicide? ..... ☐ Yes ☐No

Do you have a plan for suicide? ..... ☐ Yes ☐No

Have you gathered anything needed for your plan? ..... ☐ Yes ☐No

Do you have access to items needed to kill yourself? ..... ☐ Yes ☐No

Do you intend to carry out this plan? ..... ☐ Yes ☐No

Have you had any suicide attempts in the past? ..... ☐ Yes ☐No

Do you know anyone who has completed suicide? Explain_____. ☐ Yes ☐No

Any sudden change in symptoms? ..... ☐ Yes ☐No

Do you have any thoughts of harming others? ..... ☐ Yes ☐No

Who/Intent/Plan?_____

Do you have access to guns/weapons in the home? ..... ☐ Yes ☐No

How can they be secured for safety?_____

Clinical Form: #03-0340
Revised Date: 10/14/2024
Admin Procedure Ref: #03-003-0010
EHR: Health Services, Other Health Documents Note: Mental Health Services Emergency Pre-Admission Screening

Have you had any Hallucinations? Type?_____ ☐ Yes ☐No

Delusional thoughts present? ..... ☐ Yes ☐No

Are you able to care for yourself/basic needs independently?..... ☐ Yes ☐No

Has your appetite increased/decreased? ..... ☐ Yes ☐No

Are you experiencing any issues with sleep? ..... ☐ Yes ☐No

Explain your sleep schedule/patterns_____

Any changes in hygiene habits?..... ☐ Yes ☐No

History of psychiatric hospitalizations? ..... ☐ Yes ☐No

Explain: _____

Do you have a support system? Who? _____ ☐ Yes ☐No

Has your interest level/enjoyment in activities changed? ..... ☐ Yes ☐No

Are you employed? Where? _____ ☐ Yes ☐No

Are you on probation, parole, or facing any legal changes? ..... ☐ Yes ☐No

Substance Abuse

Substance	***Age First Used***	***Last Time Used***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been to rehab? ..... ☐ Yes ☐No

When:_____ Where: _____

BAC today: _____ Current UDS results: _____

Physician contacted:_____ Time of contact:_____

Disposition:_____

_____

_____

Diagnosis

1.) _____ 2.)_____

3.) _____ 4.)_____

_____ _____

Signature Date

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