Precious Haven, Inc.
Pre-Admission Team Review Form

Personal Information
First Name: _________________________ Middle: ______________ Last Name: ________________________

DOB: __________Age: ____ SSN: _______ - _____ - ________ M / F________ Race ___________________

Address: ____
(Street) (City) (State) (Zip Code) (County)

Phone: (___)__________________Home/Cell Marital Status: __________ Spouse Name: _________________________

School Division (If applicable): __________________ School Attending: ________________________Grade: ___________

Special Ed.: Y or N (If under age 18)

Mother: ___________________________ Address: _____________________________ Phone: ____________ Home/Cell

Father: ____________________________ Address: ____________________________ Phone: ____________ Home/Cell

Legal Custodian ☐ Unknown Name: _________________________Phone: ____________Address:________________

Emergency Contact: Name ___________________Relationship to Person: _______________ Phone _______________

Address: ____
(Street) (City) (State) (Zip Code) (County)

Medicaid: ☐Yes ☐ No ☐ Unknown # __________________________Subscriber Name: _______________________
Insurance: ☐Yes ☐ No ☐ Unknown explain: ____
(Name of Company/ Group/Plan/Number)

Collateral Sources
☐ Individual Requesting Evaluation ☐ Family/Significant Other/Guardian ☐ Treatment Records
☐ Treating Physician/Psychiatrist ☐ CSB Case Manager or Other Staff ☐ Police/First Responders
☐ CIT Officer ☐ WRAP Plan ☐ Advance Directive ☐ Safety & Support Plan
Is CSA (Comprehensive Services Act) involved with minor? ☐Yes ☐ No ☐ Unknown
Is Department of Social Services involved with individual? ☐Yes ☐ No ☐ Unknown
Comments:____
____

Presenting Crisis Situation
Referral Source: ___________________________ Consultation Location: _________________________________

Reason for Referral:
____
____

Assessment:
____
____

Behavioral Health Treatment/Services
Current Outpatient Treatment: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA)
☐ Developmental Services
☐ Private Provider or ☐ CSB Name: ____________________________________ Phone:
____

Case Manager: ____ Phone:
____

Psychiatrist: ____ Phone:
____

Prior Inpatient Treatment: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA) ☐ Developmental Services
Name/Location of Last Tx facility: _____________________________________ Adm. Date: _______Discharge Date: ________
Number of Hospitalizations: ________
Ever in a State facility? ☐ Yes ☐ No Name: _____________________________________ Date: ___________
Ever in a Crisis Stabilization Unit? ☐ Yes ☐ No Name: ___________________________ Date: ____________
Other: ____
☐ WRAP Plan ☐MOT ☐ PACT/ICT ☐ NGRI ☐ Advance Directive ☐ Safety & Support Plan ☐ Group Home
☐ Day Treatment ☐ Prevention Services ☐ In-Home Provider Name: _____________________☐ Other: _________

Substance Abuse Assessment

☐ No current use ☐ No history of use ☐ Refuses to answer

Drug Type	Priority	Age of 1st Use	Frequency of Use/Amount	Method of Use	Date of Last Use/Amount
Primary					
Secondary					
Tertiary					

History of substance abuse ☐ (Drugs, alcohol, mood altering substances, marijuana, prescription medications, inhalants)
Comment: ____________________

Have you or anyone else ever felt you had a drug or alcohol problem? ☐ Yes ☐ No
Have you received inpatient or outpatient SA treatment? ☐Yes ☐No; Maintenance services? ☐Yes ☐No
Number of prior episodes of any drug: ____________ Detoxification treatment? ☐ Yes ☐ No
Name/Location of last treatment facility: ____________________ Date of Discharge: ___________

Medical Primary Care Provider: ____________________Phone: _______________
Medical history and current medical symptoms or issues:

Medication: **Please see attached medication list** ☐ **Please see attached medical addendum** ☐
Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)
Name Dose Schedule Physician
1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8. ____________________
Recent medication change? ☐ Yes ☐ No ☐ Unknown Date of change: ____________________
Describe change: ____________________
Allergies (including food) or adverse side effects to medications: ☐ Yes ☐ No ☐ Unknown; Described:

Risk Assessment/Clinical Options (Minor)
Because of mental illness:
☐The minor presents a serious danger to ☐self or ☐others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; or
☐Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, as evidenced by: ☐delusional thinking or ☐by a significant impairment of functioning in hydration, nutrition, self protection or self control; and
☐Gang Affiliated, if so which: ____________________
☐The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment.
Findings: ____________________

The minor's parents/guardians ☐were or ☐were not consulted. The minor's treating or examining physician, if applicable, ☐was or ☐was not consulted.
Treatment and support options:
Inpatient treatment ☐is or ☐is not the least restrictive alternative that meets the minor's needs
☐Outpatient or less restrictive services has been tried with the following results:

☐Outpatient or less restrictive service has *not* been tried and is *not* likely to be adequate because:

Risk Factors
☐Aggressive behavior ☐Sexual acting out ☐Self injurious behavior ☐Elopement ☐Actively psychotic
☐Suicidal ideation ☐Homicidal ideation ☐Plan ☐Access to weapons

☐ Other

Protective Factors Required:

Final Disposition

☐Admission Approved ☐Admission Denied ☐Admission pending (No Vacancy)

Preadmission Screening Evaluator Signature Date

Board Preadmission Screening Evaluator Signature Date Board