NEW AVENUES / MBHN: Initial Clinical Assessment

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When to submit this form: **MBHN** ⇨ After First Session, if prior auth. is required
EAP ⇨ For Referral into Behavioral Health Benefit, if prior auth. is required

I. Demographics: Assessment Date: _____
Client Name: _____
Policy ID: _____ Birth Date: _____
People Present: _____

II. Client (or employer) Presented the Following Concerns:
_____
_____
_____
_____
Client's Level of Subjective Distress: ❒ Low ☐ Moderate ☐ Significant ☐ Severe

III. Type of Initial Referral:
❒ MBHN Self-Referral
❒ EAP Level II
- ❒ Self-Referral (EAP to Insurance)
- ❒ Management Referral
- ❒ Fitness for Duty
- ❒ DOT
- ❒ Other

IV. This client is being assessed for:
❒ Fitness for Duty
❒ Management Referral
❒ Treatment beyond EAP – must meet criteria of medical necessity.
❒ Specialized service not covered by EAP
❒ Other_____

V. Chemical Abuse/Dependency: ❒ None user/abstainer ❒ Experimental ❒ Social/Recreational ❒ Self-Medicating ❒ Loss of Control
❒ Self/Others concerned about usage ❒ Compulsive use ❒ Continued use (despite adverse consequences)
❒ Other: _____
Family History of Abuse/Dependence: ❒ Father ❒ Mother ❒ Grandfather ❒ Grandmother ❒ Sibling ❒ Spouse ❒ Child
Prior History of Abuse/Dependency: ❒ Yes ☐ No ❒ Recovering (describe recovery program in Section XI.) Date of last use? _____
Currently using? ☐ Yes ☐ No What?_____
Amount: _____ Frequency: _____ Length of Use_____
Length of Most Recent Period of Sobriety: _____ Comments:(use Section XI for additional comments)

VI. Signs & Symptoms/Functioning: (Check all applicable items & select from the drop down menu the degree of impact. Unchecked items are considered "Not Applicable".

Legend:
1 = MILD **impacts** quality of life, but no significant effect upon day-to-day functioning
2 = MODERATE **significant impact** on quality of life and/or day-to-day functioning
3 = SEVERE **marked impact** on quality of life and day-to-day functioning

❒ Family Conflict	Select One	❑ Depression	Select One
❒ Marital/Couple Conflict	Select One	❑ Sleep Disturbance	Select One
❒ Unresolved Grief	Select One	❑ Appetite Change	Select One
❒ Parenting Difficulties	Select One	❑ Lethargic	Select One
❒ Child Behavioral Problems	Select One	❑ Hopeless	Select One
❒ Aggressive Behavior	Select One	❑ Guilt	Select One
❒ School Performance	Select One	❑ Anxiousness	Select One
❒ Attention Problems	Select One	❑ Panic Attacks	Select One
❒ Hyperactivity	Select One	❑ Phobias	Select One
❒ Developmental Delays	Select One	❑ Obsessive/Compulsive	Select One
❒ Eating Disorder	Select One	❑ Gambling	Select One
❒ Health Concerns	Select One	❑ Psychotic Symptoms	Select One
❒ Somatic Complaints	Select One	❑ Paranoid Thinking	Select One
❒ Sexual Dysfunction	Select One	❑ Thought Disorder	Select One
❒ Low Self-Esteem	Select One	❑ Impaired Memory	Select One
❒ Anger/Temper problem	Select One	❑ Self-Care Impairment	Select One

Anorexia Nervosa ☐ Yes ☐ No
Binging/Purging ☐ Yes ☐ No
Trauma Victim ☐ Yes ☐ No
Trauma Perpetrator ☐ Yes ☐ No
Abuse Victim ☐ Yes ☐ No
Other

Symptoms have been present for:
❒ less than 1 month ❒ 1-6 months ❒ 7-12 months ❒ more than 12 months

VII. Organic Indicators:

	Not Assessed ☐	Yes	No
Oriented x 3		❒	❒
Impaired Memory		❒	❒
Tangential		❒	❒
Below Average Intelligence		❒	❒
Overly Preoccupied with Detail		❒	❒
Impaired Level of Consciousness		❒	❒
Decrease Attention Span		❒	❒
Other Cognitive Impairment		❒	❒

Explain: _____
_____

Other:
❒ Medical Concern: _____ Select One
❒ Psychological Concern: _____ Select One
❒ Other: _____ Select One
_____
_____
_____
_____
_____

New Avenues / MBHN Initial Clinical Assessment (ICA)

Client Name _____

VIII. Medication: (List all psychotropic & other medications) Not Assessed ❒

Has the patient been evaluated for medication? ❒ Yes ❒ No Prescribing Physician: _____

Current Medication: ❒ None ❒ Psychotropic ❒ Medical ❒ Other: _____

Medication	Dosage/Frequency	Start Date	Medication	Dosage/Frequency	Start Date
①			③		
②			④		

Overall Health Issues if any: _____

II. Prior Treatment: (Check all that apply) Not Assessed ❒

	Psychiatric	Chemical Dependency
Traditional Outpatient (Individual/Group)	❒	❒
Partial Hospitalization/IOP	❒	❒
Inpatient	❒	❒

(❒ Past Year ❒ Past 5 Years ❒ 10+ Years)

IX. Risk Assessment: Not Assessed ❒

(Check all that apply)	Suicidality	Homicidality
Not Present	❒	❒
Ideation	❒	❒
Plan	❒	❒
Means	❒	❒
Prior Attempt	❒	❒

Any issues of violence in client or client's family history or current situation at home or work?

❒ Yes ❒ No If yes, please explain:

X1. ICD 10 Codes

I_____ Description _____

II_____ Description _____

III _____ Description _____

Co-morbid Conditions_____

X. Clinical Overview: Briefly summarize any factors, which may impact the treatment process (e.g., pertinent history, concomitant issues, family dynamics, and support systems):

_____

_____

_____

_____

_____

_____

(Required field to complete)

XIII. Patient was offered a consent form to coordinate care:

with PCP? ❒ Yes ❒ No Patient agreed? ❒ Yes ❒ No

If yes, date communication occurred_____

by: ❒ Verbal ❒ Written

If no communication has occurred within the last year

indicate reason: ❒ No attempt has been made by this provider.

❒ Provider attempted with no success.

XII. Treatment Plan Summary: Focus of Treatment: - Objectives for treatment

#1: _____

#2: _____

Outcomes: Be specific about behavioral & functional improvements anticipated:

_____

_____

XIV. Access to care:

First appointment offered within 10 days of patients call?

❒ Yes ❒ No If No, Why?

❒ Patient declined initial appointment offered

❒ Appointment within 10 days was not available

❒ Other _____

Frequency of Sessions: ❒ **Weekly** ❒ **Every Two Weeks** ❒ **Monthly** ❒ **Other (explain):** _____ _

Modalities: ❒ Individual ❒ Family ❒ Couple ❒ Group ❒ Other ❒ Self- Help/Community

CD Treatment Recommended: ❒ Individual ❒ IOP ❒ Detox ❒ Classes ❒ AA ❒ Relapse/Aftercare

XV. Expected Treatment Outcomes: (check all that apply)

	Goal #1	Goal #2
• Problem resolution & discharge.	❒	❒
• Transfer to self-help group or other community support services.	❒	❒
• Provide ongoing treatment through insurance benefit or self-pay.	❒	❒
• Refer for Psych Evaluation, Med Evaluation or other services.	❒	❒

This plan has been discussed with patient and/or guardian

❒ Yes ❒ No

# of SESSIONS REQUESTING NOW: _____ DATE AUTHORIZATION SHOULD BEGIN: _____EXPECTED DATE of COMPLETION (Month/Year): _____

Provider's Name (Print):_____Provider's Signature:_____ Date Signed:_____

Provider's Practice Name: _____ Practice Location:_____City/St/Zip:_____