Date of Referral: _____

HOPE Referral

Client Name/ID#: _____ Date of Birth: _____

Gender: Male ◯ Female ◯ SS#: _____

Primary Language: _____

Parent/Guardian Name: _____

Phone #: _____

Address: _____

School/College: _____

IEP: Yes ◯ No ◯ Grade: _____

Employer/Address *(if applicable)*: _____

Do you have reliable transportation for appointments? Yes ◯ No ◯

Primary Insurance: _____ ID#: _____

Secondary Insurance (if applicable): _____ ID#: _____

Reason for Referral:

_____

_____

_____

Referral Source: _____

How did you hear about us? _____

Are symptoms drug induced? Yes ◯ No ◯

Is client active with Drug & Alcohol Services? Yes ◯ No ◯ If yes, where? _____

Describe psychotic symptoms that the client has reported or demonstrated over the past 12-months (include the date of onset and course of qualifying symptoms, and any self-harm, suicide attempts or violent behaviors).

_____

_____

_____

dw 1/10/2024

Date of Referral: _____

Identify other psychiatric issues that client has reported/demonstrated over the past 12-months?

◯ Depression Describe symptoms and time frame: _____

◯ Mania Describe symptoms and time frame: _____

◯ Substance Abuse Describe symptoms and time frame: _____

◯ Other _____ Describe symptoms and time frame: _____

Indicate whether the individual has any of the following challenges:

◯ Intellectual or Development Disabilities Indicate Severity: _____

◯ Learning Disabilities Indicate Type: _____

Give brief psychiatric history, including relevant information regarding psychiatric hospitalizations or other treatment and current and past medications.

_____

_____

_____

Describe any known family psychiatric history:

_____

_____

_____

Describe any relevant medical history:

_____

_____

_____

Primary Diagnosis:

_____

_____

_____

Date of Referral: _____

Circle one that applies:

a. Two or more psychiatric inpatient treatment in the past twelve months.
b. Without case management services child would result in placement in a community inpatient unit, state mental hospital or other out-of-home placement, including foster home or juvenile court placement.
c. Currently receiving or in need of mental health services and receiving or in need of services from two or more human services agencies or public systems such as education, Child Welfare, Juvenile Justice, etc.
d. Other, recommendation by the County Administrator and written approval by the Department's Area Office of Mental Health
e. Recommended by CCBHO as needing services:
    i. Person who recommended it: _____

_____ _____

Staff Signature, Credentials, Title Date

This section completed by HOPE TEAM

Therapist: _____ Initial Assessment Date: _____

Medications? ◯ Yes ◯ No Prescriber: _____

PE Appointment Date: _____

Releases Current:

___ School _____ C&Y _____ PCP _____ Behavioral Health Care Provider _____ CSC

___ JPO _____ SS _____ DPW _____ Parent _____ Other

Date of Hope Team Notified via Email: _____

HOPE, HELP AND HEALING

Children's Service Center a behavioral health organization

HOPE Program
PRIME Screen Positive Symptoms Assessment

Client Name/ID#: _____ Date of Assessment: _____

The following questions ask about your personal experiences. We ask about your sensory, psychological, emotional, and social experiences. Some of these questions may seem to relate directly to your experiences and others may not. Based on your experiences **within the 2 past years,** please tell me how much you agree or disagree with the following statements. Please listen carefully and tell me the answer that best describes your experiences.

		Definitely Agree	Some Agreement	Slightly Agree	Not Sure	Slightly Disagree	Some Disagreement	Definitely Disagree
1	I think that I have felt that there are odd or unusual things going on that I can't explain	6	5	4	3	2	1	0
2	I think that I might be able to predict the future	6	5	4	3	2	1	0
3	I may have felt that there could possibly be something interrupting or controlling my thoughts, feelings, or actions	6	5	4	3	2	1	0
4	I have had the experience of doing something differently because of my superstitions	6	5	4	3	2	1	0
5	I think that I may get confused at times whether something I experience or perceive may be real or may be just part of my imagination or dreams	6	5	4	3	2	1	0
6	I have thought that it might be possible that other people can read my mind, or that I can read others' minds	6	5	4	3	2	1	0
7	I wonder if people may be planning to hurt me or even may be about to hurt me	6	5	4	3	2	1	0
8	I believe that I have special natural or supernatural gifts beyond my talents and natural strengths	6	5	4	3	2	1	0
9	I think that I might feel like my mind is "playing tricks": on me	6	5	4	3	2	1	0
10	I have had the experience of hearing faint or clear sounds of people or a person mumbling or talking when there is no one near me	6	5	4	3	2	1	0
11	I think that I may hear my own thoughts being said out loud	6	5	4	3	2	1	0
12	I have been concerned that I might be "going crazy"	6	5	4	3	2	1	0

Continue to the next page if there are any responses with a rating of 4 or above.

How long has it been since you first had this thought or experience?

		Rating 0-3	< 1 mo	Between 1 month and 1 year	> 1 year but not lifetime	Lifetime or as Long as I can Remember	Unknown
1	I think that I have felt that there are odd or unusual things going on that I can't explain	0	1	2	3	4	9
2	I think that I might be able to predict the future	0	1	2	3	4	9
3	I may have felt that there could possibly be something interrupting or controlling my thoughts, feelings, or actions	0	1	2	3	4	9
4	I have had the experience of doing something differently because of my superstitions	0	1	2	3	4	9
5	I think that I may get confused at times whether something I experience or perceive may be real or may be just part of my imagination or dreams	0	1	2	3	4	9
6	I have thought that it might be possible that other people can read my mind, or that I can read others' minds	0	1	2	3	4	9
7	I wonder if people may be planning to hurt me or even may be about to hurt me	0	1	2	3	4	9
8	I believe that I have special natural or supernatural gifts beyond my talents and natural strengths	0	1	2	3	4	9
9	I think that I might feel like my mind is "playing tricks: on me	0	1	2	3	4	9
10	I have had the experience of hearing faint or clear sounds of people or a person mumbling or talking when there is no one near me	0	1	2	3	4	9
11	I think that I may hear my own thoughts being said out loud	0	1	2	3	4	9
12	I have been concerned that I might be "going crazy"	0	1	2	3	4	9

Have you ever talked to a counselor, psychologist, social worker, psychiatrist, or some other professional about your feelings or problems with your mood or behavior? Yes ◯ No ◯

If yes, who was it and why did you speak to them? _____

_____

How many separate times did you go see them? _____

How long did you see someone in total? _____

About how many talk sessions did you receive in total? _____

Did you receive a diagnosis? ◯ Yes ◯ No

If yes, what was your diagnosis? _____

Are you currently taking medications because of your emotions and/or behaviors? Yes ◯ No ◯

If yes, what medications are you taking and why? _____

_____

Have you ever had to go to a hospital and stay overnight because of problems with your mood, feelings, or how you were acting? ◯ Yes ◯ No

If yes, when and what happened that led to you going to the hospital? _____

Age	Description of Issues	Diagnosis	Nights in Hospital

Have you or anyone else (like your friends, parents or teachers) ever thought you needed help because of problems with your mood, feelings or how you were acting? ◯ Yes ◯ No

If so, what did they say? _____

Are you working or in school/college? ◯ Yes ◯ No

If not, why? _____

If yes, have you or others noticed changes in how you are doing at work/school/college? _____

Have you or others noticed:

a. Changes in your appearance?
   If yes, explain: _____

b. Difference in how you spend time with others, or who you spend time with?
   If yes, explain: _____

Summary:

_____

_____

_____

_____

◯ MEETS CRITERIA FOR HOPE PROGRAM

◯ DOES NOT MEET CRITERIA FOR HOPE

If not reason: _____

Follow-up: _____

_____

Date of Scheduled Intake: _____

_____ _____

Assessor's Signature – Credentials/Title Date