New Avenues
Maximizing Human Productivity and Well-Being

NEW AVENUES / MBHN: Initial Clinical Assessment

❒ ICA - MBHN
❒ Level II - EAP

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When to submit this form:
MBHN ⇨ After First Session; **EAP** ⇨ For Referral Into Behavioral Health Benefit

I. Demographics: Assessment Date: ____________________
Client Name: ______________________________
SSN/Case #: ______________ 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
❒ Job Jeopardy
❒ 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 & **Circle** the degree of impact - items unmarked 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	1 2 3	❒ Depression	1 2 3	Anorexia Nervosa
❒ Marital/Couple Conflict	1 2 3	❒ Sleep Disturbance	1 2 3	❒Yes ❒No
❒ Unresolved Grief	1 2 3	❒ Appetite Change	1 2 3	
❒ Parenting Difficulties	1 2 3	❒ Lethargic	1 2 3	Binging/Purging
❒ Child Behavioral Problems	1 2 3	❒ Hopeless	1 2 3	❒Yes ❒No
❒ Aggressive Behavior	1 2 3	❒ Guilt	1 2 3	
❒ School Performance	1 2 3	❒ Anxiousness	1 2 3	Trauma Victim
❒ Attention Problems	1 2 3	❒ Panic Attacks	1 2 3	❒Yes ❒No
❒ Hyperactivity	1 2 3	❒ Phobias	1 2 3	
❒ Developmental Delays	1 2 3	❒ Obsessive/Compulsive	1 2 3	Trauma Perpetrator
❒ Eating Disorder	1 2 3	❒ Gambling	1 2 3	❒Yes ❒No
❒ Health Concerns	1 2 3	❒ Psychotic Symptoms	1 2 3	
❒ Somatic Complaints	1 2 3	❒ Paranoid Thinking	1 2 3	Abuse Victim
❒ Sexual Dysfunction	1 2 3	❒ Thought Disorders	1 2 3	❒Yes ❒No
❒ Low Self-Esteem	1 2 3	❒ Impaired Memory	1 2 3	
❒ Anger/Temper problem	1 2 3	❒ Self-Care impaired	1 2 3	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:______________________________1 2 3
❒ Psychological Concern: ______________________________1 2 3
❒ Other: ______________________________1 2 3
____
____
____
____
____

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:

____

____

X. DSM-IV Diagnosis:

AXIS I: Primary: ___________ Secondary: ___________

AXIS II: Primary: ___________ Secondary: ___________

AXIS III: ___________________

AXIS IV: ___________________

AXIS V: (current GAF): ___________

AXIS V: (past year GAF): ___________

Global Assessment of Functioning (GAF) Scale

91-100 Superior Functioning
81-90 Minimal Symptoms
71-80 Mild/Transient Symptoms
61-70 Mild Symptoms
51-60 Moderate Symptoms/Moderate Living Impairment
41-50 Serious Symptoms/Serious Living Impairment
31-40 Impaired Reality Testing/Major Living Impairment
21-30 Inability to Function in Almost All Areas of Life
11-20 Some danger to self/others
01-10 Serious danger to self/others

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

____

____

____

____

____

____

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

#1: ___________________

#2: ___________________

Outcomes: Be specific about behavioral & functional improvements anticipated:

____

____

XIII. Provider Coordination of Care with PCP:

❒ Patient has signed consent form

❒ Patient declined to sign consent form

❒ Provider has not discussed consent form with Patient

Communicated with PCP by: ❒ Verbal ❒ Written

Date of communication with PCP: ___________

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**

NUMBER of SESSIONS REQUESTING NOW: ________ **DATE AUTHORIZATION SHOULD BEGIN:** ___________

EXPECTED DATE of COMPLETION (Month/Year): ___________ **Date Signed:** ___________

Provider's Name (Print): ___________ **Provider's Signature:** ___________