State of Illinois
Department of Human Services

Uniform Screening and Referral Form

Agency: _____ Date of Pre screening: _____

Location/Setting of Screening: _____ Location Phone Number: _____

Begin Time: _____ ◯A.M. ◯P.M. End Time: _____ ◯A.M. ◯P.M. Total Time: _____
Hours: Minutes

If screening an individual from another area, has the home agency been consulted/notified? ◯Yes ◯No*

* if "No", please notify within 24 hours

First Name: _____ MI: _____ Last Name: _____

Street Address: _____ City & State: _____ County: _____

Telephone: _____ Preferred Language: _____ Religion: _____

Date of Birth: _____ Sex: ◯Male ◯Female Social Security Number: _____

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Ethnic Group: ☐ White ☐ African American ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Alaskan Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Family/Contact Person: _____ Relationship: _____

Address: _____ City & State: _____ Zip: _____

Telephone: _____

Guardian: _____ Type of Guardianship: _____

Address: _____ City & State: _____ Zip: _____

Telephone: _____

Are there any dependents in the individual's care or responsibility? ◯Yes ◯No

If Yes, describe number, age and gender of dependents and arrangements made for their care and supervision:

Has the individual received non-crisis services from an Illinois state-funded community mental health center **in the last 6 months**?

◯Yes ◯No ◯Unknown

Financial Information (Check all that apply)

Income Source: ☐ PA ☐ SSI/SSDI ☐ Employed ☐ Family ☐ Student ☐ Retirement ☐ None

Medical Coverage: ☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ VA ☐ None

Presenting Problem: Include chief complaint (quotes when possible), history of present illness, individual's perception of problem and service needs, current stressors, time course of symptoms, what has worsened to point of need for acute care, what issues prevent community care. Include any physical, sexual, or psychological abuse (perpetrator or victim) treatment needs.

Mental Health History: Include type/location of treatment (inpatient/ outpatient, etc.). response to treatment, level of engagement with services, level of recovery, and time course of co-morbid conditions/treatment.

Substance Use/ Dependency:

Substance	Frequency/ Pattern	Last Use (date and time)	Comments*
Alcohol			
Marijuana			
Cocaine			
Methamphetamine			
Other (opiates, inhalants, etc.)			

* Include risk factors for detox (frequency and amount consumed in the last 24 hours, current BAL/ Tox.), psychiatric risk (persistence of symptom after sobriety, suicide attempts, assaults, or risk to others during intoxication/ use, physical problems after using, etc.)

Review of Physical Status/ Medical Needs: Summary of patient and ER staff reports including allergies and medical conditions currently requiring treatment.

Medications: Please attach a complete listing of medications: name, dosage, route, last dose given, and source of information. If disposition is to refer the individual to a nursing facility or hospital, attaching the list of medications is strongly recommended. For referral to a state operated hospital (SOH), the list of medications is required.

Personal History/ Current Status: Past and current level of social, vocational, and self-care functioning, use of support system, family history, minor children or elderly in the household that require care legal/ corrections history, **including current felony charges.**

Assets/ Strengths:

Mental Status (check all that apply and describe findings, as needed):

General Appearance:
- ☐ appropriately dressed
- ☐ inappropriately dressed
- ☐ appropriately groomed
- ☐ inappropriately groomed
- ☐ cooperative
- ☐ uncooperative
- ☐ other _____

Affect:
- ☐ appropriate
- ☐ inappropriate to content
- ☐ labile
- ☐ flattened
- ☐ saddened
- ☐ elevated
- ☐ other _____

Speech:
- ☐ normal rate and rhythm
- ☐ fast/pressed
- ☐ slowed/paucity
- ☐ slurred
- ☐ mute
- ☐ other _____

Psychomotor:
- ☐ no abnormalities
- ☐ restless/agitated
- ☐ slowed
- ☐ involuntary movements
- ☐ poor impulse control
- ☐ other _____

Mood:
- ☐ euthymic
- ☐ dysphoric
- ☐ euphoric
- ☐ anxious
- ☐ angry/irritable
- ☐ other _____

Memory:
- ☐ immediate memory intact
- ☐ immediate memory impaired
- ☐ recent memory intact
- ☐ recent memory impaired
- ☐ remote memory intact
- ☐ remote memory impaired

Cognition:
- ☐ no deficits
- ☐ impaired attention/concentration
- ☐ impaired abstraction (concrete)
- ☐ impaired level of consciousness
- ☐ other _____

Intelligence:
- ☐ above average
- ☐ average
- ☐ below average
- ☐ unable to assess

Thought Process:
- ☐ goal directed/linear
- ☐ tangential
- ☐ loosened associations
- ☐ incoherent
- ☐ thought blocking
- ☐ other _____

Thought Content:
- ☐ appropriate
- ☐ paranoid delusions
- ☐ grandiose delusions
- ☐ auditory hallucinations
- ☐ visual hallucinations
- ☐ ideas of reference
- ☐ thought insertion
- ☐ thought broadcasting
- ☐ obsessions/compulsions
- ☐ phobias
- ☐ disassociations
- ☐ hopelessness
- ☐ worthlessness
- ☐ excessive guilt
- ☐ dangerousness (to self or others)

Orientation:
- ☐ oriented to person
- ☐ oriented to place
- ☐ oriented to date/time
- ☐ oriented to situation

Insight:
- ☐ good
- ☐ fair
- ☐ poor

Special Needs:
- ☐ hearing impairment
- ☐ language interpreter
- ☐ visual impairment
- ☐ physical impairment
- ☐ other _____

Judgement:
- ☐ good
- ☐ fair
- ☐ poor

Comments on Additional Observations and Significant Findings:

Level of Violence Risk: **Describe past and current history of suicidal or homicidal ideation, plans, attempts, lethality of attempts, access to firearms, threats of violence, violence towards others, other dangerous behaviors, including most recent violent behavior toward self or others:**

Level of Risk of Dangerousness/ Violence to Self: ◯ Low ◯ Moderate ◯ High

Level of Risk of Dangerousness/ Violence to Others: ◯ Low ◯ Moderate ◯ High

Diagnostics Conclusions (include co-morbid conditions, differential diagnoses)

Source: ◯ Screening Assessment ◯ Medical record/ Chart

Primary Diagnosis: _____

Secondary Diagnoses: _____

_____

_____

_____

Medical Diagnoses: _____

_____

_____

_____

Provider to Which the Individual Will be Referred:

Name: _____

Address: _____

City/ State: _____ Zip: _____

Telephone: _____

Note: For all referrals to a SOH, please attach all lab results, a copy of physical history and exam, petition and first certificate. Unless specifically waived by the SOH physician, routine labs: CBC, chemistry panel, and toxicology.

I have evaluated this individual and their mental health treatment needs on the basis of face-to-face examination or observation.

_____ _____
Printed Name Date

_____
Signature/ Credential