Intensive Community Based Services

Initial Request Form

Medica

Your Agency name: _____

Name of Agency staff who met with client: _____

Agency staff phone number: _____

Date of Initial Screening/meeting with client: _____

Client Name: _____ **DOB:** _____

Parent/Guardian Name if a minor: _____

Address: _____ **Phone:** _____

Are they currently involved in Rule 79? Y ☐ N ☐

Are they eligible for Rule 79? Y ☐ N ☐

Diagnosis: _____

SX: Sadness ☐ Mania ☐ Low energy ☐ Low Motivation ☐ Angry ☐ Anxiety ☐ Sleep ☐ Impulsive ☐ Compulsive ☐
Delusions ☐ Hallucinations ☐ Disorganized Speech ☐ Obsessive ☐ Concentration ☐ IQ/Cognitive issues ☐
Difficulty completing activities of daily living (ADL's) ☐ Aggressive ☐ Truant ☐ Runaway ☐ Disorganized Behavior ☐

Stressors: Economic Housing ☐ Occupational ☐ Legal ☐ Social ☐ School ☐ Family Relationships ☐

Support System: _____

Current Medical Symptoms: _____

Substance Abuse Assessed: ☐ Y ☐ N **Problem?** ☐ Y ☐ N (note below if referrals made)

Risk Assessment: ***Suicidality***: None ☐ Ideation ☐ Plan ☐ ***Homicidality***: None ☐ Ideation ☐ Plan ☐

*Contracting for safety? Self_____ Others_____

Medications: ☐ Y ☐ N **Med List:** _____

_____

In the last 7 days, how many days were medications taken as prescribed? _____ (#of days)

In the past month, how many appointments were scheduled? _____ **How many were kept?** _____

Treating Providers: _____

_____

Current Client Needs: _____

_____

_____

Planned Interventions/Goals: _____

_____

Barriers: _____

_____

Referrals Made: _____

_____

Authorization start date: _____

For HDC or Central MN Mental Health ONLY:
Location: Urban ☐ Rural ☐

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