1- _____

NEW AVENUES / MBHN: Initial Clinical Assessment

❒ ICA - MBHN
❒ Level II - EAP

Employee Assistance Program · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980
Midwest Behavioral Health Network · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980

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

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

_____

_____

_____

_____

_____

_____

X1. DSM 5 Diagnosis

Primary _____ Description: _____

Secondary: _____ Description:_____

Co-Morbid Issues_____

_____

(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:_____