



## CARE REPORT | CLINICAL EVALUATION

**FROM: BHS CARE TEAM**

**TO: SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO**

CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., SAN DIEGO, CA 92101

EAST COUNTY DIVISION, 250 E. MAIN ST., EL CAJON, CA 92020

NORTH COUNTY DIVISION, 325 S. MELROSE DR., VISTA, CA 92081

SOUTH COUNTY DIVISION, 500 3<sup>RD</sup> AVE., CHULA VISTA, CA 91910

**ATTN:** \_\_\_\_\_

**RESPONDENT INFORMATION:**

Respondent's Name: \_\_\_\_\_ Case #: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Petition #: \_\_\_\_\_

Address: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

City: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Court Date: \_\_\_\_\_ Time: \_\_\_\_\_ State: \_\_\_\_\_

Primary Health Insurance: Choose an item. Location: \_\_\_\_\_

Secondary Health Insurance: Choose an item. If Private or Other: \_\_\_\_\_

If Private or Other: \_\_\_\_\_

**PETITIONER INFORMATION**

BHS Originating Petition  BHS Non-Originating Petition; if so:

Originating Petitioner's Name: \_\_\_\_\_ Petition Date and Time: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_

**APPOINTED COUNSEL INFORMATION**

Appointed Counsel Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Email: \_\_\_\_\_

**SUPPORTER INFORMATION (If applicable)**

Supporter's Name: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_

Relationship to Respondent: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_



## CARE REPORT | CLINICAL EVALUATION

### A. NOTICE | PROOF OF SERVICE

	CARE-115	CARE-113	CARE-116	BHS POS (If No CARE-115)	CLINICAL EVALUATION
<b>Respondent</b>	<input type="checkbox"/> Attached				
<b>Respondent's Counsel</b>	<input type="checkbox"/> Attached			<input type="checkbox"/> Attached	<input type="checkbox"/> Attached
<b>Joined Local Entity</b>	<input type="checkbox"/> Attached			<input type="checkbox"/> Attached	
<b>Supporter</b> (after written or oral consent in court)	<input type="checkbox"/> Attached			<input type="checkbox"/> Attached	

### B. EVALUATION OR ATTEMPTS MADE AT EVALUATION OF RESPONDENT (Select One)

- I, \_\_\_\_\_, was able to complete an assessment/evaluation of the respondent on \_\_\_\_\_. *(Date must be within 30 days of case management hearing.)*
- I have made attempts on the following dates to evaluate the respondent but was unsuccessful due to the respondent's being unavailable/unable/unwilling to participate in an evaluation.

Date of Attempt	Type of Attempt	Respondent's Response to Attempt	Outcome of Attempt

### C. CLINICAL EVALUATION

- Presenting Problems/Needs:** *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present. Describe Respondent-identified problem(s), as well as history and impact of presenting problem(s), on Respondent. Include impairment(s) identified by the Respondent including distress, disability, or dysfunction in an important area of life. Describe any experience of trauma. Include summary of Respondent's request for services including Respondent's most recent baseline).*



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2. **Past Psychiatric History:** *(Previous history of symptoms and/or mental health treatment. Describe in chronological order-where, when, and length of time of acute and chronic conditions. Include dates and provider related to any community-based treatment, including providers, therapeutic modality [e.g., medications, therapy, rehabilitative interventions, etc.], and response to interventions. Include prior psychiatric inpatient admissions and/or crisis-based admissions).*

3. **Cultural Information:** *(Considerations could include language of Respondent/family, primary language spoken at home, religious or spiritual beliefs, family structures, customs, moral/legal systems, lifestyle changes, socio-economic background, ethnicity, race, tribal or BIPOC affiliation, LGBTQ affiliations, immigration history/experience, age, and subculture [homelessness, gang affiliations, substance use, foster care, military background], exposure to violence, abuse, and neglect, experience with racism, discrimination, and social exclusion. Describe unique cultural and linguistic needs and strengths that may impact treatment. Please include an understanding of how Respondent's mental health is impacted).*

**D. SUBSTANCE USE**

- 1. Does the respondent have a co-occurring substance use disorder?      Yes                      No                      Unable to Assess
- 2. Does respondent have a history of substance use?                      Yes                      No                      Refuse/Unable to Assess

*If yes, please complete table:*

Name of Drug	Method of Administration	Age 1 <sup>st</sup> used	Days of use in last 30 days	Date of last use

- 3. Does respondent have a history of substance use treatment?      Yes                      No                      Unable to Assess



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*If yes, please include treatment providers, therapeutic modality (e.g. medication-assisted treatment, rehabilitative interventions, intoxication/detox/withdrawal management-based admissions) and response to interventions:*

### E. PHYSICAL HEALTH

1. Does respondent have a Primary Care Physician? Yes No Unable to Assess

*If yes:*

Primary Care Physician Name: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Last seen: \_\_\_\_\_

2. Does respondent have physical health issues? Yes No Unable to Assess

*If yes, please describe:*

### F. FUNCTIONAL ASSESSMENT

1. Please describe the following:

Personal care skills:

Activities daily living:

Community living skills:

Social skills:

Community educational/work activities:

Somatic safety:

Inattentive smoking       AWOL       Assault       Fire setting       Inappropriate sexual behavior

2. Illness Management:

Access to treatment (transportation):  Yes  No

Knowledge of mental health status:  Yes  No

Knowledge of illness:  Yes  No



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3. Does the respondent have any nursing needs (ambulation, incontinence, etc)?  Yes  No  Unknown  
 If yes, please list:

4. Does the respondent have a Psychiatric Advance Directive?  Yes  No  Unknown  
 If yes, date completed: \_\_\_\_\_ Attachment Included:  Yes  No

### G. MENTAL HEALTH EXAM

Unable to assess at this time. Please explain:

**Level of Consciousness**

Alert  Lethargic  Stuporous

**Orientation**

Person  Place  Day  Month  Year  Current Situation  
 None

**Appearance**

Good Hygiene  Poor Hygiene  Malodorous  Disheveled  Reddened Eyes  
 Normal Weight  Overweight  Underweight

**Speech**

Normal  Slurred  Loud  Soft  Pressured  Slow  Mute  
 Other:

**Thought Process**

Coherent  Tangential  Circumstantial  Incoherent  Loose Association

**Behavior**

Cooperative  Uncooperative  Evasive  Threatening  Agitated  Combative

**Affect**

Appropriate  Restricted  Blunted  Flat  Labile  Other:

**Intellect**

Average  Below Average  Above Average  Poor Vocabulary  
 Poor Abstraction  Paucity of Knowledge  Unable to Rate

**Mood**

Euthymic  Elevated  Euphoric  Irritable  Depressed  Anxious

**Memory**

Normal  Poor Recent  Poor Remote  Inability to Concentrate  
 Confabulation  Amnesia



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**Motor**  Age Appropriate/Normal  Slowed/Decreased  Psychomotor Retardation  
 Hyperactive  Agitated  Tremors  Tics  Repetitive Motions  Other:

**Judgement**  
 Age Appropriate/Normal  Fair  Poor  Unable to Rate  
 Limited  Unrealistic

**Insight**  
 Age Appropriate/Normal  Fair  Limited  Poor  Unable to Rate

**Symptoms of Psychosis**

Command Hallucinations  No  Yes, specify:  
 Auditory Hallucinations  No  Yes, specify:  
 Visual Hallucinations  No  Yes, specify:  
 Tactile Hallucinations  No  Yes, specify:  
 Olfactory Hallucinations  No  Yes, specify:  
 Delusions  No  Yes, specify:

Other observations/comments when applicable:

**H. PROSPECTIVE RISK ANALYSIS**

1. Has respondent had suicidal ideation in the past 12 mos.?  Yes  No  Unable to Assess  
 If yes:  
 Thoughts but not intention or plan?  Yes  No  Unable to Assess  
 Thoughts with intention, but no plan?  Yes  No  Unable to Assess  
 \*Thoughts, intention, and plan? (methods/means?)  Yes  No  Unable to Assess
2. Does respondent have past suicidal behaviors?  Yes  No  Unable to Assess  
 (Things to consider: first attempt, most serious attempt, substance involvement, complications, how was it prevented?)
3. Has respondent had assaultive/homicidal ideation or impulses in the past 12 months?  Yes  No  Unable to Assess  
 If yes:  
 Thoughts/impulses, but not intention or plan?  Yes  No  Unable to Assess  
 Thoughts/impulses with intention, but no plan?  Yes  No  Unable to Assess  
 \*Thoughts/impulses with intention and plan?  Yes  No  Unable to Assess



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4. Are there firearms or access to firearms/other lethal means in the home?  Yes  No  Unable to Assess  
*(Indicate in Overall Risk Assessment how this will be addressed, access limited or removed)*

5. Does the respondent have past assaultive behaviors?  Yes  No  Unable to Assess  
*(Things to consider toward property or animals, toward people, domestic violence, antisocial, intimidation, predatory)*

6. Does respondent have non-suicidal self-injurious behaviors?  Yes  No  Unable to Assess  
*(Things to consider method, severity, frequency, remote vs. ongoing)*

7. Does the respondent have any recent (within the past 12 months) activating stressors?  Yes  No  Unable to Assess  
 (Select all that apply)

- Family/primary support group
- Social Environment
- Economic/occupational/educational problems
- Housing problems
- Health problems
- Legal problems
- Other:

8. If yes, are these stressors experienced as “catastrophic” or insurmountable?  Yes  No  Unable to Assess

9. Does the respondent have any historic stressors?  Yes  No  Unable to Assess  
*(Select all that apply)*

- Family/primary support group
- Social environment
- Economic/occupational/educational problems
- Housing problems
- Health problems
- Legal problems
- Other:

10. If yes, are these stressors experienced as “catastrophic” or insurmountable?  Yes  No  Unable to Assess



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### 11. CONCURRENT CLINICAL FACTORS:

Active severe mental illness or serious emotional disturbance not yet stabilized or in remission?  Yes  No  Unable to Assess

Active self-destructive and/or impulsive personality traits such as that found in borderline, histrionic and/or antisocial personality disorder?  Yes  No  Unable to Assess

Active moderate or severe substance use disorder and/or recent relapse?  Yes  No  Unable to Assess

Active physical illness which causes severe pain, immobility, life dysfunction or risk of death?  Yes  No  Unable to Assess

\*Currently experiencing hopelessness, excessive guilt/responsibility/family burden, isolation, extreme psychological pain and suffering, extreme bullying/victimization or making pre-death arrangements?  Yes  No  Unable to Assess

\*Currently experiencing confusion, paranoia, command auditory hallucinations, restlessness/agitation, anxiety/panic or severe sleep disturbance?  Yes  No  Unable to Assess

**12. Overall Risk Assessment:** *(Based on the above analysis, along with the completed comprehensive assessment, summarize concerns with respect to Respondent's risk for suicide, self-injury, and violence, and situations/triggers that may induce risky behaviors. In addition, be sure to address any Yes response).*



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### I. CLINICAL CONCLUSIONS

1. Based on the information in this evaluation, I have reason to believe Respondent meets the diagnostic criteria for CARE Act proceedings:

	Yes	No	Unable to determine
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a. The Respondent meets diagnostic criteria for a schizophrenia spectrum disorder or another psychotic disorder in the same class.

	Yes	No	Unable to determine
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Primary Diagnosis: Choose an item.

Secondary Diagnosis(es):

b. The Respondent presents meeting diagnostic criteria that is primarily psychiatric in nature and does not appear to be schizophrenia or other psychotic disorder *which is the result of a physical health condition*, such as, but not limited to: traumatic brain injury, autism, dementia, or neurologic conditions, or a substance use disorder. ***(Please indicate any evaluation, tests, or medical screenings provided to ensure that the Respondent's condition is not due to an excluded medical/substance use condition).***

	Yes	No	Unable to determine
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2. The Respondent is experiencing a serious mental illness that (all must be completed):

	Yes	No	Unable to determine
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(a) *Is severe in degree and persistent in duration and impacts functioning (explain in detail):*

(b) *Causes behavior(s) that impair functioning and/or interferes substantially with the primary activities of daily living (i.e., what is their level of functioning?)(explain in detail):*

(c) *Results in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period (explain in detail):*



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3. Respondent is not clinically stabilized in ongoing voluntary treatment (explain in detail): *(include information regarding the Respondent's clinical baseline, reasons why treatment is not working, what has been done to attempt to clinically stabilize Respondent in voluntary treatment, and who is the current treatment provider).*

Yes                      No                      Unable to determine

4. At least one of these is true (complete one or both of the following):                      Yes                      No                      Unable to determine

Respondent is unlikely to survive safely in the community without supervision and respondent's condition is substantially deteriorating (explain in detail) *(why Respondent is unlikely to survive safely in the community, the type of supervision Respondent would need to survive safely, and the extent to which Respondent's physical or mental condition has recently deteriorated).*

Respondent needs services and supports to prevent a relapse or deterioration that would likely result in grave disability or serious harm to respondent or others (explain in detail):

Neither of the above are true/ Unable to determine (explain in detail):



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5. Does the Respondent have the legal capacity to give informed consent regarding psychotropic medication?

Please explain in detail:

Yes

No

Unable to Determine

6. Participation in a CARE Plan or CARE Agreement would be the least restrictive alternative necessary to ensure Respondent's recovery and stability (explain in detail):

Yes

No

Unable to Determine

(a) What alternative treatments are available: *(ACT, SBCM, Outpatient, etc.)*

(b) Why no alternative treatment that would be less restrictive of Respondent's liberty could ensure Respondent's recovery and stability:

7. Respondent is likely to benefit from participation in a CARE plan or CARE agreement. Explain in detail how participating in a court-ordered CARE agreement or plan would help Respondent:

Yes

No

Unable to determine



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8. **CLINICAL FORMULATION:** Include a summary of clinical and diagnostic impressions, medical necessity determination, and an analysis of recommended services, programs, housing, medications, and interventions that support the recovery and stability of the Respondent:

9. Please include any other information as ordered by the court or that the licensed behavioral health professional conducting the evaluation determines would help the court make future informed decisions about the appropriate care and services the Respondent should receive:



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### CLINICAL ATTESTATION

Clinician's Name: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_  
City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Email: \_\_\_\_\_

**License Status (complete either a or b):**

**a.** I am a licensed mental health professional and conducting the examination described on this form is within the scope of my license. I have a valid California license as a (check one):

- Physician
- Psychologist
- Clinical Social Worker
- Marriage and Family Therapist
- Professional Clinical Counselor

License #: \_\_\_\_\_

**b.** I have been granted a waiver of licensure by the State Department of Health Care Services pursuant to Welfare and Institutions Code section 5751.2 because (check one):

- (1) I am employed as a
- Psychologist
  - Clinical Social Worker
  - Continuing my employment in the same class as of January 1, 1979, in the same program or facility

(2) I am registered with the licensing board of the State Department of Health Care Services for the purposes of acquiring the experience required for licensure and employed or under contract to provide mental health services as a (check one):

- Clinical Social Worker
- Marriage and Family Therapist
- Professional Clinical Counselor

(3) I am employed or under contract to provide mental health services as a psychologist who is gaining experience required for licensure.

**I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.**

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Clinician name, title, program

\_\_\_\_\_  
Signature of Clinician



## CARE REPORT | CLINICAL EVALUATION

### ATTACHMENTS:

- Release of Information
- Behavioral Health Assessment
- Behavioral Health treatment records
- Medication Records
- Psychiatric Assessment
- Client/Service Plan
- Physician Orders
- Diagnosis
- Billing records
- History & Physical Exam
- Alcohol/Drug Treatment Records
- Laboratory Results
- Medical Records/Imaging/Procedures
- Progress Notes
- Pharmacy Records
- Psychological Evaluation
- Nursing Notes
- Other: