CARE REPORT | CLINICAL EVALUATION

RESPONDENT:

NAME:

BHRS Petitioner ☐ Non-BHRS Petitioner ☐

Originating Petitioner's Name:

APPOINTED COUNSEL INFORMATION

Appointed Counsel Name:

SUPPORTER INFORMATION (If applicable)

Supporter Name:

Relationship to Respondent:

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

CLINICAL EVALUATION

1. Presenting Problems/Needs: *(Include precipitating factors that led to deterioration/behaviors, Respondent-identified problem(s), history, trauma, and impact of presenting problem(s). Include impairment(s) including distress, disability, or dysfunction.)*

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2. Past Psychiatric History: *(Previous history of symptoms and/or mental health treatment. Describe acute and chronic conditions. List community-based treatment, therapeutic modality [e.g., medications, therapy, rehabilitative interventions, etc.], and response to interventions. List prior psychiatric inpatient admissions and/or crisis-based admissions).*

3. Cultural Information: *(Examples include language of Respondent/family, religious or spiritual beliefs, 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, etc.)*

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 1st 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:

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

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

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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

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

Auditory Hallucinations	☐ No	☐ Yes
Visual Hallucinations	No	Yes
Delusions	No	Yes

Other observations/comments if applicable:

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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? *(Things to consider: first attempt, most serious attempt, substance involvement, complications, how was it prevented?)*	☐ Yes	☐ No	☐ Unable to Assess
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
4. Are there firearms or access to firearms/other lethal means in the home? *(Indicate in Overall Risk Assessment how this will be addressed, access limited or removed)*	☐ Yes	☐ No	☐ Unable to Assess
5. Does the respondent have past assaultive behaviors? *(Things to consider toward property or animals, toward people, domestic violence, antisocial, intimidation, predatory)*	☐ Yes	☐ No	☐ Unable to Assess
6. Does respondent have non-suicidal self-injurious behaviors? *(Things to consider method, severity, frequency, remote vs. ongoing)*	☐ Yes	☐ No	☐ Unable to Assess

7. **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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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

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

   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

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

   (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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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

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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/Imagining/Procedures
- ☐ Progress Notes
- ☐ Pharmacy Records
- ☐ Psychological Evaluation
- ☐ Nursing Notes
- ☐ Other: