

NORTH COUNTRY COMMUNITY MENTAL HEALTH

1 Intake Addendum New Information/Status Change Update Re-Admission

Check a box for each area that has changed. Provide a separate narrative for each box checked.

- | | | |
|--|---|--|
| <input type="checkbox"/> 2 Presenting concerns | <input type="checkbox"/> Leisure/stress management | <input type="checkbox"/> Psychiatric history/treatment |
| <input type="checkbox"/> Family/interpersonal | <input type="checkbox"/> Financial | <input type="checkbox"/> Health |
| <input type="checkbox"/> Impressions of
parent/guardian | <input type="checkbox"/> Employment | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Living arrangements | <input type="checkbox"/> Vocational/educational
training | <input type="checkbox"/> Legal issues |
| <input type="checkbox"/> Self-care | <input type="checkbox"/> Psycho-educational needs | |
| <input type="checkbox"/> 3 Risk history: | <input type="checkbox"/> Homicidal/violence | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Suicidal/self-abuse | <input type="checkbox"/> Abuse/neglect | <input type="checkbox"/> New/other: _____ |

4 Mental status: _____

Narrative:

5 Diagnosis Change: Axis I Axis II Axis III Axis IV Axis V

6 Source and Credentials of Author of Diagnosis: _____

7 Assessments Completed: Basis-32 CAFAS Folstein NC SNAP Other: _____

8 Update Narrative: (Provide a separate narrative for each box checked)

Consumer Name	ID #	Date
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9 Summary/Justification for Continued Care:

10 Disability Designation

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Evaluated	Developmental Disability: Meets the 1996 Mental Health Code Definition of Developmental Disabilities regardless of whether they received services from the DD or MI service arrays.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Evaluated	Mental Illness: Has DSM-IV diagnosis, exclusive of mental retardation, developmental disability or substance abuse.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Evaluated	Substance Abuse Disorder: As defined in Section 61-7 of the public health code.

11 Service Designation

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if the person is receiving services that are primarily designed for people with DEVELOPMENTAL DISABILITIES , regardless of this person's diagnosis or disability designation.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if the person is receiving services that are primarily designed for MENTAL ILLNESS regardless of this person's diagnosis or disability designation.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if the person is receiving services that are primarily designed for people with SUBSTANCE ABUSE DISORDERS , regardless of this person's diagnosis or disability designation.

Signatures:

CMH Representative	Date	CMH Supervisor	Date		
Physician (If applicable)	Date	Other	Date		
Start Time	Stop Time	Duration	Location	Activity Code	Cost Center

Consumer Name	ID #	Date
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