Adult Pre-Affidavit Screening

Time of Notification/Call:	If CMHC is unable to complete the PAS, explanation must be provided of why not:
***Must be completed/screened within 24 hours**	
Less restrictive alternative treatment considered: ☐ Yes ☐ No If yes, less restrictive treatment was considered, specify why involuntary commitment is recommended and less restrictive treatment is not appropriate:	
PAS Completion Date: Time In: Time Out:	Interview Location: In-person: ☐ Yes ☐ No | If not, explain: In-Jail: ☐ Yes ☐ No | If yes, explain why Proposed Person is in jail:
Individuals Present:	
Interpretative Aids/Assisted Devices:	Pending Felony Charges: ☐ Yes ☐ No
Mobile Crisis Involvement: ☐ Yes ☐ No	CMHC Region:
	Voluntary CSU Admission Sought: ☐ Yes ☐ No

Advise the following to the *Proposed Person:* Information from this interview will be reported on a standardized form and submitted to the chancery court and civil commitment examiners. You have the right to refuse to participate. Other sources of information including a review of your legal medical records and interviews with family members and the Interested Person requesting commitment will be included in this report.

Proposed Person

Name:	DOB:	**Age: Gender: Race:**
Social Sec #:	Medicaid #:	Medicare#:
Home Address:		Phone Number:
Proposed Person resides with minor children: ☐ Yes ☐ No		Name & Ages of Children:
Proposed Person resides has visitation rights to minor children: ☐ Yes ☐ No		Name & Ages of Children:
Proposed Person resides has legal guardian/conservator: ☐ Yes ☐ No		Name & Ages of Children:
Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other		

Interested Person/Relative

Interested Person/Relative Name:	Relation to Proposed Person:
Phone Number:	Home Address:
Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other	

Proposed Person Psychosocial Information

Current Living: ☐ Alone ☐ Family/Friends ☐ Assisted Living ☐ Homeless ☐ Other/Describe:
Does the Proposed Person currently have stable and independent living arrangements: ☐ Yes ☐ No

Housing:	Dwelling: Marital Status:	Home Address:
Employed: ☐ Yes ☐ No	Employer/Position:	Length of Job:
If unemployed (most recent job?):		Highest Level of Education Completed:
Religious Preference or Practice:		
Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other		

Psychiatric

Current Psychotropic Medications:	Dosage & Date/Time Last Taken:	Is the medication helpful or problematic:

Psychiatric Hospitalizations: Has the Proposed Person had 2 or more psychiatric hospital or emergency admissions in the past 12 months: ☐ Yes ☐ No	Locations/Dates: Enter Location and Date
Outpatient Treatments:	Locations/Dates:
Psychological Testing:	Provider/Dates:

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Medical Status & Treatment

Current Medications (not listed above):	Dosage & Date/Time Last Taken:	Is the medication helpful or problematic:

Known Medication Allergies:

Currently Under Physician Care For:	Physician's Name:
Conditions Treated in The Past:	Provider/Dates:
Medical Hospitalization History:	Physical Disabilities:

Current Communicable Diseases:

☐ HIV/AIDS ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ TB (Tuberculosis)

☐ MRSA ☐ Influenza ☐ Head Lice ☐ Scabies ☐ Body Lice ☐ STIs ☐ Other

Currently Pregnant: ☐ Yes ☐ No

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Developmental Disability

History of Special Education Ruling: ☐ Yes ☐ No	If yes, describe:
Documented IQ below 70: ☐ Yes ☐ No	If yes, describe:
Documented sub-average intellectual functioning before age 18: ☐ Yes ☐ No	If yes, describe:
Documented Adaptive Functioning Deficits: ☐ Yes ☐ No	If yes, describe:

Specific Observed Adaptive Functioning Deficits:

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Mental State Exam

Oriented to Date: **Time:** **Place:**

*Cue for three words (provide words)

President:

Counting Response:

Word Recall:

Completed Written Command: ☐ Yes ☐ No If no, describe:

What do you understand the reason for our meeting today to be?

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Psychiatric Symptoms Past Month

Proposed Person (P) Interested person/relative (I)

Depressive Symptoms	P	I	Anxiety Symptoms	P	I	Somatic Symptoms	P	I
☐ Depressed mood most of the day	☐	☐	☐ Worry	☐	☐	☐ Headaches	☐	☐
☐ Lack of Interest/Pleasure	☐	☐	☐ Restlessness	☐	☐	☐ Chest Discomfort/Pain	☐	☐
☐ Appetite Change or Sig Weight Change	☐	☐	☐ Easily Fatigued	☐	☐	☐ Faintness	☐	☐
☐ Insomnia (Difficulty Falling Asleep)	☐	☐	☐ Irritability	☐	☐	☐ Hot or Cold Flashes	☐	☐
☐ Feelings of Worthlessness	☐	☐	☐ Muscle Tension	☐	☐	☐ Stomach Aches/Pains	☐	☐
☐ Fatigue or Loss of Energy	☐	☐	☐ Difficulty Concentrating	☐	☐	☐ Heart Palpitations	☐	☐
☐ Diminished Concentration	☐	☐	☐ Sleep Disturbance	☐	☐	☐ Dizziness or Vertigo	☐	☐

Psychiatric Symptoms Past Month

Proposed Person (P) Interested person/relative (I)

☐ Indecisiveness	☐	☐	☐ Other	☐	☐	☐Shaking/Trembling	☐
☐ Hypersomnia (Sleeping Excessively)	☐	☐				☐Tingling in hands or feet	☐
☐ Recurrent Thoughts of Death	☐	☐				☐Excessive Sweating	☐
☐ Motor Retardation	☐	☐				☐ Other	☐ ☐
☐ Motor Agitation	☐	☐					
☐ Feelings of Hopelessness	☐	☐					
☐ Other	☐	☐					

Mania & Hypomania Symptoms	P	I		P	I
☐ At least 1 week	☐	☐	☐ More talkative than usual	☐	☐
☐ 4 consecutive days < weeks	☐	☐	☐ Excessive involvement in activities with high potential for painful consequences	☐	☐
☐ Flight of ideas/racing thoughts	☐	☐	☐ Distractibility	☐	☐
☐ Decreased need for sleep	☐	☐	Persistent elevated, or irritable mood and significant increases in goal directed activity ☐ Yes ☐ No	☐	☐
☐ Increased self-esteem of Grandiosity	☐	☐			

Thought Disorder Symptoms	P	I		P	I
☐ Hallucinations	☐	☐	☐ Absence of emotions	☐	☐
☐ Auditory ☐Visual ☐Olfactory	☐	☐	☐Absence of speech	☐	☐
☐ Tactile ☐Gustatory	☐	☐	☐Absence of movement	☐	☐
Specific Hallucinations:	☐	☐	☐ Lack of Hygiene	☐	☐
☐ Delusions	☐	☐	☐Lack of eating/feeding	☐	☐
☐Persecutory ☐Grandiose ☐Paranoid ☐ Other	☐	☐			
Specific Delusions:					

Obsessive Compulsive Symptoms	P	I		P	I
Obsessive Thoughts ☐Yes ☐No	☐	☐	Compulsive Behaviors ☐Yes ☐No	☐	☐
Severity: ☐Mild ☐Moderate ☐Severe	☐	☐	Severity: ☐Mild ☐Moderate ☐Severe	☐	☐
Specific Obsessions:	☐	☐	Specific Compulsions:	☐	☐

Trauma History

Trauma Exposure ☐Yes ☐No (type/approx. Date)				
Trauma Triggers:				
Environmental	☐ Crowding	☐ Room checks	☐ Confusing signs	☐ Slamming doors
	☐ Leaving bedroom door open	☐ Dark room	☐ Too hot or too cold	☐ Noise
Interpersonal	☐ Lack of privacy ☐ Confined spaces ☐ Being stared at ☐ Being approached by women	☐ Being approached by men or women ☐ Being touched ☐ Being ignored ☐ Being Teased/picked on ☐ Tall or large	☐ Arguments ☐ People too close ☐ Feeling pressured ☐ People focusing on my symptoms	☐ People Yelling ☐ Contact with Family ☐ Being ordered to do something ☐ Smells
Other Triggers	☐ Taste ☐ Time of Day	☐ sounds ☐ Sights	☐ Sensations/textures	☐ Wringing hands
Warning Signs of Emotional escalations	☐ Heart Pounding ☐ Clenching teeth ☐Bouncing legs ☐ Sweating	☐ Shortness of Breath ☐ Flushed/red face ☐Singing ☐ Rocking	☐ Breathing Hard ☐ Crying ☐ Can't sit still ☐ Pacing	☐ Wringing hands ☐ Clenching fists ☐ Cursing/swearing ☐ Giggling

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Suicide Assessment

Prior Attempts:	Friend or Family Member Completed Suicide:
Approximate Date:	Approximate Date:
Method of attempt:	Method of suicide:

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

History or Present Danger to Self: ☐ Yes ❒ No | If yes, mark appropriate statement(s) below:			
❒ Thoughts of suicide	❒ Threats of suicide	❒ Plan for suicide	❒ Pre-occupation with death
❒ Suicide gesture	❒ Suicide attempts	❒ Family history of suicide	❒ Self-mutilation
❒ Inability to care for self	❒ High risk behavior	❒ Provoking harm to self from others	
❒ Other			
Describe: _____			

Substance Use

Do you currently use? ☐ Yes ☐ No

	Past Use	Amount	Frequency	Age of Initiation
Caffeine				
Nicotine				
Alcohol				
Marijuana				
Opioids				
Amphetamines				
Hallucinogenic				
Prescription Medication				
Over the counter medication				

History of legal charges related to substance use? ☐ Yes ☐ No — Describe:

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Physical Appearance

	Attire	**Hair**	**Nails**	**Skin**	
☐ Glasses	☐ Appropriate for occasion	☐ Clean	☐ Clean	☐ Clean	☐ Bruised
☐ Contacts	☐ Appropriate for weather	☐ Dirty	☐ Dirty	☐ Dirty	☐ Cuts/Scrapes
☐ Hearing Aids	☐ Clean	☐ Disheveled		☐ Tattoos Describe:	
	☐ Dirty	☐ Styled			
	☐ Torn/worn through			☐ Sores	
	☐ Other				
Teeth	Unusual alterations or distinguishing features:				
☐ Clean					

☐ Dirty	
☐ Decay	
☐ Missing	

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Behavioral Observations				
Motor Activity				
Diminished	Normal	Excessive	Unusual	
☐ Frozen	☐ Purposeful	☐ Restless	☐ Other	
☐ Catatonic	☐ Coordinated	☐ Squirming		
☐ Almost motionless	☐ Other	☐ Fidgety		
☐ Little animation		☐ Constant movement		
☐ Psychomoto rretardation		☐ Hyperactive		
☐ Slowed reactiontime		☐ Other		
☐ Other				
Speech				
Slowed	Normal	Pressured	Verbose	Unusual
☐ Minimal response	☐ Initiates	☐ Excessively wordy	☐ Over productive	☐
☐ Unspontaneous	☐ Alert/responsive	☐ Expansive	☐ Long winded	
☐ Sluggish	☐ Productive	☐ Rapid	☐ Nonstop	
☐ Paucity	☐ Animated	☐ Fast	☐ Frequent run-ons	
☐ Impoverished	☐ Spontaneous	☐ Rushed	☐ Flight of ideas	
☐ Single word answers	☐ Smooth	☐ Other	☐ Hyper verbal	
☐ Other	☐ Other		☐ Other	
Thought Process				
Attention	Insight	Preoccupations		
☐ Normal	☐ Good	☐ Somatic	☐ Self	
☐ Unengaged	☐ Fair	☐ Children	☐ Finances	
☐ Distractible	☐ Poor	☐ Spouse/Sig Other	☐ Other	
☐ Hyper vigilant	☐ No insight	☐ Job		
☐ Hyper focused				

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Behavioral Observations				
Affect				
☐ Flat	☐ Blunted	☐ Constricted	☐ Normal	☐ Broad
Facial Expression				
☐ Vacant				
☐ Blank				
☐ Strained				
☐ Pained				
☐ Grimacing				
☐ Smiling				
☐ Other				

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Violence Risk Assessment

Current thoughts about harming another person ☐ Yes ☐ No

If Yes, whom:

If yes, how long have you had these thoughts?

If yes, specific plan:

Access to means to carry out plan:

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Violence Risk Factors Present

Present	Unknown		Present	Unknown	
☐	☐	Male sex	☐	☐	Substance Abuse
☐	☐	Suspiciousness/Perception of hidden threat	☐	☐	Comorbid MI & Substance Use Dx
☐	☐	Early offense history	☐	☐	Anger
☐	☐	Psychopathy (PCL:SV>12)	☐	☐	Antisocial Personality Diagnosis
☐	☐	Violent Fantasies	Frequency, type, recency		
☐	☐	Previous violence against other people	Frequency, severity, type		
☐	☐	Childhood physical abuse	Frequency, severity		

Source of Information: ☐ Proposed Person ☐ Interested Person/Relative ☐ Chart Review ☐ Other

Note: *Per HB 1640, "Actively Violent" is defined as behavior that presents an immediate and serious danger to the safety of the individual or another, the individual has inflicted or attempted to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated.*

Actively Violent: ☐ Yes ☐ No

☐ Individual presents behavior that is an immediate and serious danger to the safety of the individual or another; or

☐ has inflicted or attempted to inflict serious bodily harm on another; or

☐ has acted in such a way as to create a substantial risk of serious bodily harm to another; or

☐ has engaged in extreme destruction of property; AND

There is a reasonable probability that the conduct will be repeated.

Summary & Recommendations

Based on the data gathered for the current Pre-Affidavit Screening, the interviewer certifies:

☐ It is **NOT** recommended that this Proposed Person receive a civil commitment exam.

- Current available information indicates that present symptomatology is due to:
  ☐ Dementia ☐ Intellectual/Developmental Disability ☐ Epilepsy ☐ Chemical Dependency ☐ Mental Illness

List specific reasons for rejecting or recommending alternatives to involuntary commitment:

1)

2)

3)

4)

- **Must Complete Referrals/Alternative Treatment Page for appropriate supports and services.**

☐ It **IS** recommended that this Proposed Person receive a civil commitment exam. Based on the data available for the current pre-affidavit screening the following symptomatology cannot be managed/treated in a less restrictive environment:

1)

2)

3)

4)

☐ Based on the definition of actively violent, the CMHC has explored and exhausted the availability of all other appropriate facilities such as their CSU, other CSUs, local hospitals, and any DMH certified facility locations.

Additional Comments:

_____
Interviewer's Signature-Credentials

_____
Interviewer's Agency

_____
County where pre-affidavit screening was filed.

Referrals/Alternative Treatment

*Please refer to the current DMH Community Transition Guide for updated referral contact information. *

Proposed Person's County of Residence: _____

Was a referral made to a Crisis Stabilization Unit (CSU)? Yes ☐ No ☐

Which CSU? _____

Was the Proposed Person accepted at the CSU? Yes ☐ No ☐

If *No,* what was the denial reason: _____

Does the Proposed Person have stable and independent living arrangements?

If *No,* then refer to CHOICE Housing Program

Referral Date: _____

CHOICE Referral Staff Contact: _____

Resolution: _____

Is the Proposed Person currently employed?

If *No,* and they want to work, then refer to Supported Employment Program

Referral Date: _____

Supported Employment Staff Contact: _____

Resolution: _____

Has the Proposed Person had 2 or more psychiatric hospital or emergency admissions in the past 12 months? OR

Does the Proposed Person present with significant and major psychiatric symptoms (e.g., suicidality, psychosis) and has not benefited from traditional outpatient services?

If *Yes,* then refer to PACT or ICORT (dependent on Proposed Person's County of residence)

Referral Date: _____

PACT/ICORT Staff Contact: _____

Resolution: _____

Is Proposed Person between 15-30 years old? Yes ☐ No ☐

Is this the Proposed Person's first episode of psychosis? Yes ☐ No ☐

If the answer is *Yes* to both, then refer to NAVIGATE First Episode Psychosis Service

Referral Date: _____

NAVIGATE Staff Contact: _____

Resolution: _____