

## Adult Assessment & Referral Tool

Provider Name

Provider Number  Employee Nbr  Zip Code of Service

Visit Number  3rd visit  5th visit or more Date of Service  /  /

**READ:** It is program policy to ask all people who visit with a crisis counselor three or more times a few specific questions about how they were affected by the disaster and how they are feeling now. May I ask you these questions?  
**IF THE PERSON IS WITH SOMEONE (OTHER THAN YOU), ADD:** Would you prefer to mark your answers on this form rather than saying them out-loud?  
 My first questions are about various experiences you may have had in the disaster.

### RISK CATEGORIES (select all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> injured or physically harmed     | <input type="checkbox"/> home had damage                    | <input type="checkbox"/> evacuated quickly with no time to prepare  |
| <input type="checkbox"/> life was threatened              | <input type="checkbox"/> displaced from home 1 week or more | <input type="checkbox"/> witnessed community destruction            |
| <input type="checkbox"/> family missing or dead           | <input type="checkbox"/> disaster unemployed                | <input type="checkbox"/> past substance use / mental health problem |
| <input type="checkbox"/> friend missing or dead           | <input type="checkbox"/> other financial loss               | <input type="checkbox"/> pre-existing physical disability           |
| <input type="checkbox"/> witnessed death / injury         | <input type="checkbox"/> assisted with rescue / recovery    | <input type="checkbox"/> past trauma                                |
| <input type="checkbox"/> prolonged separation from family |   |   |

### ASSESSMENT of EVENT REACTIONS

**GIVE RESPONSE CARD TO RECIPIENT.**

**READ:** These questions are about the reactions you have experienced IN THE PAST MONTH. By reactions, I mean your feelings or emotions or thoughts about the events. For each question choose ONE of the following responses from this card.

1  not at all    2  a little bit    3  moderately    4  quite a bit    5  very much

#### QUESTIONS TO BE READ

#### RESPONDENT'S ANSWER

How much have you been bothered by unwanted memories, nightmares, or reminders of what happened?	1	2	3	4	5
How much effort have you made to avoid thinking or talking about what happened or doing things that remind you of what happened?	1	2	3	4	5
To what extent have you lost enjoyment in things, kept your distance from people, or found it difficult to experience feelings because of what happened?	1	2	3	4	5
How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability or feeling watchful around you because of what happened?	1	2	3	4	5
How down or depressed have you been because of what happened?	1	2	3	4	5
Has your ability to handle other stressful events or situations been harmed?	1	2	3	4	5
Have your reactions interfered with how well you take care of your physical health? For example, are you eating poorly, not getting enough rest, smoking more, or finding that you have increased your use of alcohol or other substances?	1	2	3	4	5
How distressed or bothered are you about your reactions?	1	2	3	4	5
How much have your reactions interfered with your ability to work or carry out your daily activities, such as housework or schoolwork?	1	2	3	4	5
How much have your reactions affected your relationships with your family or friends or interfered with your social, recreational, or community activities?	1	2	3	4	5
How concerned have you been about your ability to overcome problems you may face without further assistance?	1	2	3	4	5

NUMBER OF RESPONSES OF 4 OR 5 (this is recipient's score) >>>

I also need to ask: Is there any possibility that you might hurt or kill yourself?  no  yes

IF YES, refer for immediate psychiatric intervention - IF NO, continue on back of this form



IF THIS IS THE 3<sup>RD</sup> COUNSELING SESSION, PLEASE USE BOX A. IF THIS IS THE 5<sup>TH</sup> SESSION, USE BOX B.

**BOX A (3<sup>RD</sup> SESSION)**

IF SCORE IS 3 OR HIGHER, READ:

FROM WHAT YOU'VE TOLD ME, IT SEEMS THAT YOU MIGHT BENEFIT FROM PARTICIPATING IN ANOTHER PROGRAM [DESCRIBE]. I WOULD LIKE TO REFER YOU TO \_\_\_\_\_.

IF SCORE IS BELOW 3, READ:

FROM WHAT YOU'VE TOLD ME, IT SEEMS THAT YOU ARE MANAGING YOUR REACTIONS. DOES THAT SEEM RIGHT TO YOU?

IF NO, READ: PERHAPS YOU WOULD BENEFIT FROM PARTICIPATING IN ANOTHER PROGRAM [DESCRIBE]. I WOULD LIKE TO REFER YOU TO \_\_\_\_\_.

IF YES, READ: WE SHOULD DECIDE UPON SPECIFIC GOALS FOR COUNSELING THAT WE CAN MEET TODAY OR WITHIN ANOTHER COUPLE OF VISITS.

**BOX B (5<sup>TH</sup> SESSION)**

IF SCORE IS 3 OR HIGHER, READ:

WE'VE MET A FEW TIMES AND WORKED ON SEVERAL SPECIFIC GOALS. FROM WHAT YOU'VE TOLD ME TODAY, IT SEEMS THAT YOU MIGHT BENEFIT FROM PARTICIPATING IN ANOTHER PROGRAM [DESCRIBE]. I WOULD LIKE TO REFER YOU TO \_\_\_\_\_.

IF SCORE IS BELOW 3, READ:

FROM WHAT YOU'VE TOLD ME, IT SEEMS THAT YOU ARE MANAGING YOUR REACTIONS. DOES THAT SEEM RIGHT TO YOU?

IF NO, READ: WE'VE MET A FEW TIMES AND WORKED ON SEVERAL SPECIFIC GOALS. PERHAPS YOU WOULD BENEFIT FROM PARTICIPATING IN ANOTHER PROGRAM [DESCRIBE]. I WOULD LIKE TO REFER YOU TO \_\_\_\_\_.

IF YES, READ: WE'VE MET A FEW TIMES AND WORKED ON SEVERAL SPECIFIC GOALS. LET'S SPEND TODAY TALKING ABOUT WHAT YOU'VE LEARNED AND WHERE YOU MIGHT GET SUPPORT IN THE FUTURE.

**REFERRAL INFORMATION**

other crisis counseling services

other disaster services (e.g., FEMA loans, housing)

other (specify in box) >

mental health treatment

substance abuse treatment

Was the referral accepted by the individual?  no  yes

IF REFERRAL IS NOT ACCEPTED, READ:

If you would like to continue to meet with me, let's decide upon some specific goals for counseling that we can meet today or in another couple of visits.

**DEMOGRAPHIC INFORMATION**

Age (select one)

adult (18-39)

adult (40-64)

adult (65+)

Sex (select one)

male

female

Ethnicity (select one)

Hispanic or Latino

not Hispanic or Latino

Race (select one or more)

American Indian / Alaska Native

Asian

Black or African American

Native Hawaiian / Pacific Islander

White

Preferred Language (select one)

English

Spanish

other (specify in box) >

Language of Contact (select one)

English

Spanish

other (specify in box) >

Parent / Guardian of Child (under 18) (select one)

no

yes

unknown

Reviewed by \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



## INSTRUCTIONS: ASSESSMENT & REFERRAL TOOL

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 5 minutes per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

### When to Use This Form:

Use this form to assess the person's need for further services during the 3<sup>rd</sup> or 5<sup>th</sup> or more sessions of individual crisis counseling.

PROVIDER NAME – The name of the program/agency.

PROVIDER # - The unique number your program/agency is providing services under.

EMPLOYEE # - YOUR employee number.

DATE OF SERVICE – The date of the encounter.

ZIP CODE OF SERVICE – The zip code of the location you had the encounter in.

TYPE OF VISIT – Based on your conversation with the individual, is this the “3<sup>rd</sup>” or “5<sup>th</sup> or more” visit for this person to your program? All visits did not have to be with you. **SELECT ONLY ONE.**

RISK CATEGORIES - These are factors that an individual may have experienced or may have present in their life that could increase their need for services. **MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.**

GIVE THE RESPONSE CARD TO THE INDIVIDUAL. This card will be used to respond to the questions on the front page.

\* For each question, put a check mark in the appropriate box based on the individual's responses.

\* At the end of the 11 questions, add the number of check marks in boxes 4 and 5. This is the person's score.

Now, ask the person if there is any possibility that he/she might hurt or kill him/herself. **If the answer is “yes,” refer the person IMMEDIATELY for psychiatric intervention according to local procedures.**

**If the answer is “NO,” TURN THE PAGE OVER AND CONTINUE.**

REFERRALS – Based on your conversation with this individual, you may have referred the individual for other services. In the REFERRAL box, select all of the types of services you referred the person to. If the service is not listed, please provide the type of service next to “OTHER SERVICES.” If you did not make a referral, please select “NONE.”

WAS THE REFERRAL ACCEPTED BY THE INDIVIDUAL? Based on your conversation with the individual, indicate whether or not the person accepted the referral information.

DEMOGRAPHIC INFORMATION – Complete this section based on your observations. **Do not ask these questions of the recipient.**

AGE – The age you perceived the person to be. **SELECT ONLY ONE**

SEX – Was the person male or female? **SELECT ONLY ONE**

ETHNICITY – Based on your observations and your conversation with the individual, what ethnicity do you think the individual was? **SELECT ONLY ONE.**

RACE - Based on your observations and your conversation with the individual, what race do you think the individual was? **SELECT ALL THAT APPLY.**

PARENT/GUARDIAN OF CHILD - Based on your observations and your conversation with the individual, is the individual the parent or guardian of a child under 18 years of age? **SELECT ONLY ONE.**

PREFERRED LANGUAGE – What language did the individual prefer to talk to you in? If “OTHER”, fill in the other language (not English or Spanish) that the person preferred to speak in. **SELECT ONLY ONE.**

LANGUAGE OF CONTACT – What language did you actually use to speak with this individual during the encounter? This may be different than the preferred language. If “OTHER”, fill in the other language (not English or Spanish) that the person spoke in. **SELECT ONLY ONE.**

**STOP!** Please submit the completed form to the designated person in your agency who will review and sign the form. **Thanks for taking the time to complete this form accurately and completely!**