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Intrust Screening Form

Date:

Client's Name: _____

Guardian's Name:_____

Custody of: (circle) Parent DCBS DJJ OTHER: _____

Has the guardian/client been contacted about this referral? Yes or No

Address:_____

Phone: _____

School/ Workplace: _____

Grade: _____ DOB or Age: _____

Referring Individual and Agency:_____ Phone: _____

Checklist for Eligibility

Check One	**Criteria**
□ Yes □ No □ Not Sure	Does the client have a medical card? MCO _____ MAID #: _____
□ Yes □ No □ Not Sure	Does client have a primary insurance: _____
□ Yes □ No □ Not Sure	Does the client have a diagnosed emotional or behavioral disorder? If so, what is diagnosis? _____
□Yes □ No □ Not Sure	Has the client been diagnosed with a Severe Mental Illness? If so, what is the diagnosis? _____
□ Yes □ No □ Not Sure	Are behaviors causing impairment to daily functioning How long have behaviors occurred: _____
□ Yes □ No □ Not Sure	Has the client had any mental health placements? How many placements in the last two years _____
□ Yes □ No □ Not Sure	Has the client ever been removed from the home? If yes, where were they placed? _____

Reasons for Referral (Check all that apply)

School	Home	Community
□ Frequent disciplinary referrals □ Sporadic disciplinary referrals □ History of suspensions □ Physically aggressive □ Destructive to property □ Truancy □ Theft □ Dishonesty □ Defiant behavior □ Hyperactivity □ Impulsivity □ Attention problems □ Unusual fears or anxiety □ Difficulty with peer relations □ Social withdrawal or isolation □ Sadness/depression □ Poor self-care/hygiene □ Irritability □ Mood swings □ Appetite problems □ Learning difficulties □ Poor grades	□ Requires frequent discipline □ Defies adults requests □ Noncompliant with chores □ Physically aggressive □ Destructive to property □ Theft □ Dishonesty □ Hyperactivity □ Impulsivity □ Attention problems □ Unusual fears or anxiety □ Social withdrawal or isolation □ Sadness/depression □ Poor self-care/hygiene □ Irritability □ Mood swings □ Appetite problems □ Sleeping difficulties □ Difficulty with sibling relations	□ History of Vandalism □ History of theft □ Physically aggressive □ Sexually promiscuous □ History of substance abuse □ Sexually abusive □ Involvement with cult or gang □ Fire setting behavior □ Seeks negative peers □ Runs away □ Other legal violations Limitations: □ Housing □ Vocational □ Social □ Educational □ Community Resources □ Self-care □ Interpersonal Relationships □ Family Life □ Self-Direction □ Education □ Removed from Home □ Unable to maintain a stable setting Has the child been seen by a therapist/ school personnel before?

Additional information: _____

_____

_____

Referral to Therapy □ Yes □ No Therapist Notified: _____ Date Notified: _____

Referral to Case Management □ Yes □ No CM Notified: _____ Date Notified: _____