DESCHUTES COUNTY HEALTH SERVICES

INTENSIVE YOUTH SERVICES BEHAVIORAL HEALTH SCREENING REQUEST

Email to: intensiveyouthservices@deschutes.org Fax: 541-617-4793 Phone: 541-213-6851

Name of referred: Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date. **Gender:** Choose an item.

Pronouns: Choose an item. **Primary Language:** Choose an item. **Parent/Guardian Name:** Click or tap here to enter text.

Address: Click or tap here to enter text. **City:** Choose an item. **Phone:** Click or tap here to enter text.

Reason for Request: Click or tap here to enter text.

Requesting Screening for:

☐ Early Assessment and Support Alliance (Ages: 12-27)

☐ Young Adults in Transition – YAT (Ages: 14-24)

☐ Wraparound – WRAP (Ages: 0-18)

☐ Parent Child Interaction Therapy – PCIT (Ages: 2-6)

☐ Generation Parent Management Training – GenPMTO (Ages 7-17)

☐ KIDS Center Referral to DCBH (Ages 0-17 - Please include collateral)

Other services (mark all that apply):

☐ Individual Education Plan / 504

☐ Primary Care Provider: Click or tap here to enter text.

☐ Medication (Provided by): Click or tap here to enter text.

☐ Individual Therapy (Provided by): Click or tap here to enter text.

☐ Youth Villages / Intercept: Click or tap here to enter text.

Multiple System Involvement (please mark all that apply):

☐ DHS

☐ Juvenile Community Justice / OYA / Probation/Parole

☐ Intellectual Developmental Disabilities

☐ Substance Use Treatment (Rimrock/Best Care/Pfeiffer)

Insurance Type:

☐ Oregon Health Plan – Pacific Source

☐ Oregon Health Plan – Fee for Service

☐ Private Insurance

☐ No Insurance

PERSON AND/OR AGENCY REQUESTING SCREENING (please print):

Name: Click or tap here to enter text. Phone Number: Click or tap here to enter text. Date: Click or tap to enter a date.

(Person and/or agency requesting the screening is not responsible for the approval or denial of the referral, the outcome of the referral or any financialobligation.)

CONSENT FOR SCREENING

Screening, evaluation, or assessment requires parent / client consent. Screening does not guarantee admission into services.

Parent/ Guardian complete for children 0 to 13 years of age / Client completes if 14 years or older

☐I give my consent to conduct the above checked mental health screening.

☐I do not give my consent to conduct the above checked screening.

Parent/Guardian SIGNATURE _____**DATE**_____

Client SIGNATURE_____ **DATE**_____

Authorization to exchange information (attached)

EASA Criteria. Must meet all of the following requirements:

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☐ Resides in Deschutes, Jefferson or Crook County
☐ Age 12-27 with an IQ over 70 or not already receiving developmental disability services
☐ No more than 12 months since diagnosed with a major psychotic disorder, if applicable
☐Psychotic symptoms are not known to be caused by the temporary or chronic effects of substance abuse or a known medical condition.
☐The person has experienced a significant decline in either academic, vocational, social or personal (sleep, hygiene) functioning.

And must meet one of the below:

☐The individual has experienced significant worsening or new symptoms in one or more of the following areas *in the last year:*

a. Thought disorganization as evidenced by disorganized speech and or/ writing. (Examples: confused conversations, not making sense, never getting to a point, unintelligible).
b. Behaviors, speech or beliefs are uncharacteristic and/or bizarre.
c. Complains of hearing voices or sounds that others do not hear.
d. The individual feels that other people are putting thoughts in their head, stealing their thoughts, believes others can read their mind (or vice versa), and/or hear their own thoughts out loud.
f. Episodes of depersonalization (Example: They believe that they do not exist or that their surroundings are not real).
g. Heightened sensitivities (lights, sounds etc.) and/or is experiencing visual distortions
h. Increased fear, anxiety or paranoia for no apparent reason or for an unfounded reason.

OR

☐Family history of a 1st degree relative (sibling or parent) with a major psychotic disorder

Young Adults in Transition Criteria

☐ Resides in Deschutes County
☐ Individual has Oregon Health Plan insurance, some private insurance or does not have any form of insurance
☐ Individual is seeking mental health support as the primary reason for seeking services.
☐ Age - Eligible youth will be from 14 through 24 years of age. Youth in need of mental health treatment- Eligible youth will be determined to have need of mental health treatment.
☐ Under supported youth: Youth that are involved with Juvenile Community Justice, Oregon Youth Authority, Department of Human Services, homeless youth and youth will minimal natural supports.
☐ Transition: Youth transitioning out of Wraparound or EASA programs. Individuals who do not meet criteria for EASA.

Wraparound / Intensive Care Coordination Criteria

☐Resides in Deschutes County
☐Individual is a capitated member of Pacific Source Oregon Health Plan or Oregon Health Plan Open Card
☐ Family is engaged and wants this level of care.
☐ Children and youth up to age 18 with two or more primary mental health diagnosis.
☐Risk for out of home placement due to mental health (psychiatric residential, behavioral rehabilitation, commercially sexually exploited children's residential program)
☐ Two or more system involvement with one of the following; special education, juvenile justice, developmental disabilities services, child welfare, mental health
☐A mental health disorder not likely to resolve in 6 months or less or previous mental health treatment has been unsuccessful
☐ Recent serious mental health episode (suicide attempt or ideation, rapid deterioration of functioning, recent hospitalization, homicidal ideation or actions)

Parent Child Interaction Therapy (PCIT) & Generation Parent Management Training (GEN-PMTO)

☐Resides in Deschutes County
☐ Family is engaged and wants this level of care.
☐ Children ages 2-6 PCIT
☐ Children ages 7-17 Gen-PMTO