San Luis Obispo County
Initial Psychiatric Evaluation

Client Name:	Client DOB:	Client ID:

Date of Assessment:		Time of Assessment:	

Reason for Referral:			
☐	MH- Outpatient Medication Evaluation	☐	SA - Outpatient Treatment
☐	SA- DUI	☐	SA - AB 109
☐	SA - Residential	☐	

Presenting Problem (Chief Complaint, patient's belief of why they are here)
History of Present Illness (What led to the current admission):

PSYCHIATRIC AND MEDICAL HISTORY				
Has patient previously received mental health treatment:	Yes		No	
If yes, describe previous mental health treatment				
Current Medications				

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Previous Medication Trials				
Responses to Previous Medications				
Medical History (surgeries, hospitalizations for physical health)				
Any Allergies or Special Precautions:	Yes		No	
	Unknown			
Does patient/client have history of Drug and/or Alcohol use history?	Yes		No	
Alcohol/Drug Use:				
Additional comments about drug and/or alcohol use history:				

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Family History (Medical/Psychiatric):	
Current Living Arrangements:	
Social/Family/Military:	

TREATMENT PLANNING				
Treatment Planning	Outpatient		Substance Abuse	
Client Strengths:				
Treatment Plan:				

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MEDICAL NECESSITY				
MEDICAL NECESSITY FOR OUTPATIENT MENTAL HEALTH SERVICES (All must be Yes for continued treatment):				
Client has included Diagnosis:	Yes		No	
Client has a significant impairment in an important area of life functioning:	Yes		No	
Specialty Mental Health Services are likely to help maintain/improve the mental health condition:	Yes		No	
Client's mental health condition would **not be responsive to treatment by a physical health care provider:**	Yes		No	
MEDICAL NECCESSITY FOR SUD TREATMENT ADMISSION				
Client has a substance use disorder diagnosis.	Yes		No	
Client meets the ASAM criteria definition of medical necessity for services based on the ASAM criteria.	Yes		No	

DISCHARGE PLANNING		
Discharge Criteria:		
Discharge Plan:		
Clinician Signature	**Title/License**	**Date**

Client ID_____