

Connecticut Department of Mental Health and Addiction Services

DDaP - CRISIS EVALUATION FORM



PROVIDER CLIENT ID: _____

NAME (Last, First, optional MI): _____

ADMISSION DATE: ____ / ____ / ____

REQUEST DATE: ____ / ____ / ____ **REQUEST TIME:** ____ : ____ ☐ AM ☐ PM

REQUESTOR TYPE: *(check one box below)*

- | | |
|--|---|
| 01 ☐ DMHAS FACILITY | 10 ☐ SHELTER/SOUP KITCHEN |
| 02 ☐ PNP AGENCY | 11 ☐ DEPT OF DEVELOPMENT SERVICES: DDS |
| 03 ☐ DEPT OF CHILDREN & FAMILY: DCF | 12 ☐ POLICE COMMUNITY RELATIONS OFFICER |
| 04 ☐ EMERGENCY DEPARTMENT | 13 ☐ NURSING FACILITY |
| 05 ☐ FRIEND/FAMILY MEMBER | 14 ☐ PRIVATE BEHAVIORAL HEALTH CLINICIAN |
| 06 ☐ SELF | 17 ☐ HOME FOR THE AGED |
| 07 ☐ PAROLE/PROBATION | 96 ☐ OTHER |
| 08 ☐ POLICE | 97 ☐ UNSPECIFIED |
| 09 ☐ COURT | |

EVALUATOR NAME: _____

EVALUATION DATE: ____ / ____ / ____ **EVALUATION TIME:** ____ : ____ ☐ AM ☐ PM

EVALUATION LOCATION: *(check one box below)*

- | | |
|---|---|
| 01 ☐ CLIENT RESIDENCE | 08 ☐ DEPT OF CHILDREN & FAMILY: DCF |
| 02 ☐ COURT | 09 ☐ DMHAS FACILITY-NON CRISIS |
| 03 ☐ NURSING HOME | 10 ☐ DEPT OF DEVELOPMENT SERVICES: DDS |
| 04 ☐ CORRECTIONAL FACILITY | 11 ☐ HOME FOR THE AGED/ASSISTED LIVING |
| 05 ☐ OTHER COMMUNITY SITE | 12 ☐ HOSPITAL ER |
| 06 ☐ CRISIS UNIT | 13 ☐ HOSPITAL OTHER THAN ER |
| 07 ☐ SHELTER/SOUP KITCHEN | 14 ☐ POLICE DEPARTMENT |

DIAGNOSIS TYPE: *(check all boxes that apply)*

- | | |
|---|--|
| 01 ☐ INADEQUATE INFORMATION | 04 ☐ PSYCHIATRIC ONLY |
| 02 ☐ NO SIGNIFICANT PSYCH OR SUBSTANCE ABUSE | 05 ☐ SUBSTANCE ABUSE ONLY |
| 03 ☐ PSYCH AND SUBSTANCE ABUSE | |

DISPOSITION REFERRAL: (check all box that apply)

- | | |
|---|--|
| 01 ☐ CRISIS/RESPITE BED | 10 ☐ RESIDENTIAL |
| 02 ☐ CRISIS FOLLOW-UP | 11 ☐ CASE MANAGEMENT |
| 03 ☐ VETERAN'S ADMINISTRATION | 12 ☐ COMMUNITY SUPPORT PROGRAM: CSP |
| 04 ☐ DEPT OF CHILDREN & FAMILY: DCF | 13 ☐ ASSERTIVE COMMUNITY TREATMENT |
| 05 ☐ DEPT OF DEVELOPMENT SERVICES: DDS | 14 ☐ OUTPATIENT (OP) |
| 06 ☐ NO REFERRAL-CLIENT REFUSED | 15 ☐ RECOVERY SUPPORTS |
| 07 ☐ NO REFERRAL-SERVICES NOT NEEDED | 16 ☐ PARTIAL HOSPITAL PROGRAM (PHP) |
| 08 ☐ NO REFERRAL-OTHER | 17 ☐ PSYCH-IP |
| 09 ☐ MEDICAL INPATIENT | 18 ☐ EMERGENCY DEPARTMENT |

POLICE DEPARTMENT: (check one box below)

- | | |
|--|--|
| 01 ☐ BRIDGEPORT | 07 ☐ WATERBURY |
| 02 ☐ GROTON | 08 ☐ WEST HAVEN |
| 03 ☐ HARTFORD | 09 ☐ STAMFORD |
| 04 ☐ NEW HAVEN | 10 ☐ WATERFORD |
| 05 ☐ NEW LONDON | 11 ☐ NORWALK |
| 06 ☐ NORWICH | |

TRANSPORT TO ED: (check one box below)

- | | |
|--------------------------------------|--------------------------------------|
| 1 ☐ NA | 4 ☐ VOLUNTARY |
| 2 ☐ POLICE | 5 ☐ AMBULANCE |
| 3 ☐ CLINICIAN | |

ARREST MADE: ☐ NO ☐ YES ☐ PENDING

MOST SERIOUS CHARGE TYPE: (check one box below)

- | | |
|--|--|
| 1 ☐ FELONY | 3 ☐ OTHER CHARGE TYPE |
| 2 ☐ MISDEMEANOR | |

CIT CLINICIAN PRESENT: ☐ YES ☐ NO

DISPOSITION DATE: ____ / ____ / ____ **DISPOSITION TIME:** ____ : ____ ☐ AM ☐ PM

FACILITY NAME: _____