Connecticut Department of Mental Health and Addiction Services

CRISIS EVALUATION FORM - DDaP

PROVIDER CLIENT ID: _____

NAME: _____

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: _____