

Screening Information Form

Section I: Youth Information

Youth ID: _____

Sex: Female Male

Age: _____

Grade: 6th 7th 8th 9th 10th 11th 12th Not in School

Interview Date: ____ / ____ / ____

Interview Time: _____

Section II: DPS Summary Report

Circle version: Computerized Paper/Pencil

Computer Used: _____

Language Used: English Spanish

Health Information:

Vision Problems Yes No
 Dental Problems Yes No
 Hearing Problems Yes No

Clinically Significant Information:

Q23: Suicide Ideation (past 3 months): Yes No
 Q24: Suicide Attempt (last year): Yes No
 Q48: Been to see someone at hospital/clinic: Yes No

Present (DPS Positive) Symptom Screens:

Social Phobia
 Panic
 Generalized Anxiety
 Obsessive Compulsive
 Depression
 Alcohol Abuse
 Marijuana Abuse
 Other Substance Abuse

Impairment Information:

PRESENT ABSENT
 Feeling Anxious or Worried
 Feeling Sad or Depressed
 Your behavior
 Alcohol or Drugs
 Other things you did

Total DPS Symptom Score: _____

Total DPS Impairment Score: _____

Clinical Evaluation Is Indicated When:

- Either of the suicide items have been endorsed ('Clinically Significant Information' above) **OR** ...
- A Specific Disorder is '**PRESENT**' in Symptom Scale **AND** Total DPS Impairment Score $\geq 6^*$ **OR** ...
- The Total DPS Symptom Score ≥ 9 **AND** the Total DPS Impairment Score $\geq 6^*$

* Impairment need not be taken into account for alcohol, marijuana or other substances.

CHECK Screen Results/Next Steps:

- POSITIVE DPS SCREEN/ Clinical Interview Indicated → Complete Sections III, IV & V
- NEGATIVE DPS SCREEN/ Clinical Interview Not Indicated → Complete Section III

Section III: Post DPS Interview

During the interview, did any thoughts, ideas, or concerns come up that you would like to talk about?

Yes No

Optional Or any other requests or needs such as tutoring, after-school programs, mentoring programs, etc.?
(tailor according to resources available/profile of youth) _____

ADD DEBRIEFING LANGUAGE (SCRIPT) FOR DPS POSITIVE AND NEGATIVE YOUTH – i.e., Thank you for participating, you are free to go back to class....invited back to speak with health specialist....a little about the negative or positive results etc...

Post-DPS Interviewers Printed Name: _____

Post-DPS Interviewers Signature/Date: _____

STOP HERE IF YOUTH WAS NEGATIVE ON DPS SCREEN & DID NOT REQUEST TO SPEAK WITH A CLINICIAN

HAVE CLINICIAN COMPLETE SECTION IV & V IF YOUTH WAS POSITIVE ON DPS SCREEN OR REQUESTED TO SPEAK WITH A CLINICIAN

Section IV: *Clinical Interview & Referral

Date of Interview: ___/___/___
 Month Day Year

Reason For Clinical Interview: Youth was seen by clinical staff as part of the TeenScreen Program due to:

- Results on the DPS Screen
- Request by the youth to see a clinician
- Other _____

Clinical Instructions

- Review 'YES' Answers from Positive DPS (or Possibly Positive) symptom screen(s) - AND --
- Fill out appropriate Symptom Checklist(s) to explore whether youth deems further evaluation and/or treatment

Symptom Checklist for Clinician Evaluation

Please check Yes (Y) if present, No (N) if absent, or Don't Know (DK) if you didn't ask about the symptom or disorder

Y	N	DK	Criteria for Social Phobia:
			Marked and persistent fear of ≥ 1 social or performance situations when exposed to unfamiliar people or possible scrutiny.
			Fear occurs in peer setting, not just interactions with adults.
			Exposure to feared social situation provokes anxiety (may be expressed by crying, tantrums, freezing or shrinking from social situations).
			Feared situations avoided or endured with intense anxiety and distress.
			Avoidance or distress from feared situation(s) interferes significantly with normal routine, academic functioning, social activities or relationships, or there is marked distress about having the phobia.
			Symptoms present for at least 6 months.
NOTES:			
Y	N	DK	Criteria for Panic Disorder: Both 1 and 2
			1) Recurrent unexpected Panic Attacks: Discrete period of intense fear or discomfort, in which ≥ 4 of the following symptoms developed abruptly and reached a peak within 10 minutes: <ul style="list-style-type: none"> a) Palpitations, pounding heart, or accelerated heart rate b) Sweating c) Trembling or shaking d) Sensations of shortness of breath or smothering e) Feeling of choking f) Chest pain or discomfort g) Nausea or abdominal distress h) Feeling dizzy, unsteady, lightheaded or faint i) Derealization (feelings of unreality) or depersonalization (being detached from oneself) j) Fear of losing control or going crazy k) Fear of dying l) Paresthesias (numb or tingling sensations) m) Chills or hot flashes

			<p>2) At least one of the attacks has been followed by at least 1 month or one or more of the following:</p> <ul style="list-style-type: none"> a) Persistent concern about having additional attacks b) Worry about the implications of the attack or its consequences (e.g., losing control, "going crazy") c) A significant change in behavior related to the attacks
			The Panic Attacks are not due to a general medical conditions (e.g., asthma)
NOTES:			
Y	N	DK	Criteria for Generalized Anxiety:
			Excessive anxiety and worry more days than not for at least 6 months, about a number of events or activities.
			The person finds it difficult to control the worry.
			The anxiety and worry are associated with ≥ 3 of the following symptoms (if over age 12) with at least some symptoms present for more days than not for the past 6 months:
			<ul style="list-style-type: none"> a) Restlessness or feeling keyed up or on edge b) Being easily fatigued c) Difficulty concentrating or mind going blank d) Irritability e) Muscle tension f) Sleep disturbance
			The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social or academic functioning.
NOTES:			
Y	N	DK	Criteria for Obsessive Compulsive Disorder:
			Either obsession or compulsions:
			<p>Obsessions defined by 1, 2, 3, and 4:</p> <ul style="list-style-type: none"> 1) Recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress 2) The thoughts, impulses, or images are not simply excessive worries about real-life problems 3) The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action 4) The person recognizes that the obsessional thoughts, impulses, or images are a product of their own mind
			<p>Compulsions defined by 1 and 2:</p> <ul style="list-style-type: none"> 1) Repetitive behavior (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly 2) The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, they are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive
			The obsessions or compulsions cause marked distress, are time consuming (take > 1 hour/day), or significantly interfere with the person's normal routine, academic functioning, or usual social activities or relationships.
NOTES:			
Y	N	DK	Criteria for Depression:
			Depressed mood most of the day, nearly every day.
			Irritable mood most of the day, nearly every day.
			Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
			Significant weight loss when not dieting, or weight increase, or decrease or increase in appetite nearly every day.

			Insomnia or hypersomnia nearly every day.
			Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
			Fatigue or loss of energy nearly every day.
			Diminished ability to think or concentrate, or indecisiveness, nearly every day.
			Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
			Symptoms have been present during the same 2-week period.
			Symptoms represent a definite change from previous functioning.
			At least one of the symptoms is either depressed/irritable mood or anhedonia.
			The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

NOTES:

Y	N	DK	Criteria for Dysthymia:
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			Depressed/irritable mood for most of the day, for more days than not, for at least 1 year.
			While depressed, poor appetite or overeating.
			While depressed, insomnia or hypersomnia.
			While depressed, low energy or fatigue.
			While depressed, low self-esteem.
			While depressed, poor concentration or difficulty making decisions.
			While depressed, feelings of hopelessness.
			During the 1-year period, the person has never been without the symptoms for more than 2 months at a time.
			The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
			Psychotic features.
			Atypical features.

NOTES:

Y	N	DK	Substance Use:
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			Alcohol (lifetime)
			Alcohol (last year) ... <i>Specify amount</i>
			Alcohol (last 4 weeks) ... <i>Specify amount</i>
			Marijuana (lifetime)
			Marijuana (last year) ... <i>Specify amount</i>
			Marijuana (last 4 weeks) ... <i>Specify amount</i>
			Other Substance (lifetime) ... <i>Specify which substance(s)</i>
			Other Substance (last year) ... <i>Specify amount</i>
			Other Substance (last 4 weeks) ... <i>Specify amount</i>

NOTES:

Y	N	DK	Criteria for Abuse: Alcohol/ Marijuana/ Other Substance
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			A maladaptive pattern of substance use leading to clinically significant impairment or distress within a 12-month period.
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		Recurrent substance use resulting in a failure to fulfill major role obligations at school, or home (e.g., repeated absences or poor school performance related to substance use; substance-related absences, suspension or expulsions).
		Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile)
		Recurrent substance-related legal problems (e.g., arrests for substance related disorderly conduct)
		Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments about consequences of intoxication, physical fights)
		The symptoms have never met the criteria for Substance Dependence for this class of substance.
NOTES:		

Suicidality acknowledged during the clinical interview:

Ideation: No Yes

Attempt: No Yes

If YES, Fill out SUICIDE CHECKLIST

Note: Parents must be informed of serious and recent suicide ideation and legitimate past attempts.

Suicide Checklist for Clinician Evaluation

Please check Yes (Y) if present, No (N) if not present, and explain positive item (please distinguish between current (past 4 weeks) and lifetime)

Active suicide ideation					
YES	NO		YES	NO	
		1. Serious thoughts about killing self			3. Significant suicide ideation (everyday for one week) in the past year
		a. onset (when began/when ended/when last)			a. when
		b. frequency (how often, days/wk)			b. frequency
		c. plan			4. Any other ideation
		d. intent (thoughts plus wish to die)			a. when
		2. Any thoughts about killing yourself			b. frequency
		a. onset (when began/when ended/when last)			c. nature/ description
		b. frequency			
		c. plan			
		d. intent (thoughts plus wish to die)			
Passive suicide ideation					
YES	NO		YES	NO	
		1. Thoughts about death			4. Wish or desire to fall asleep and never wake up
		a. onset (when began/when ended/when last)			a. onset(when began/when ended/when last)
		b. frequency (how often, days/wk)			b. duration
		c. duration			c. frequency (how often, days/wk)
		2. Thoughts about people who have died			5. Wish that you were dead
		a. onset (when began/when ended/when last)			a. onset(when began/when ended/when last)
		b. frequency (how often, days/wk)			b. duration
		c. duration			
		3. Thoughts about the experience of being dead			
		a. onset (when began/when ended/when last)			
		b. frequency (how often, days/wk)			
		c. duration			
Past history of suicide attempts					
YES	NO		YES	NO	
		1. Number of attempts			8. Disclosure(of thoughts to kill self)
		2. Date/time of last attempt			9. Specific plans
		3. Method employed (more than one?)			10. Attempts to conceal
		4. Intent (belief that your action would have led to your death)			11. Preparation for death(token items, notes)

Referral Recommended for Clinical Reasons: Yes No Emergency/Crisis: Yes No

Description of referral recommendation OR reason(s) for No Referral: _____

Youth Response to Referral: Accepted Denied Undecided Already In Treatment N/A

Summary: _____

Clinicians Printed Name: _____

Clinicians Signature and Date: _____

Section V: Case Management & Follow-up

Case Mgt. Date (began): ___/___/___
Month Day Year

Parent Response to Referral: Accepted Denied Undecided Youth Already In Treatment N/A

*1st Appointment: Date of Appointment: _____ Kept: Yes No

Referral Setting/Type of Treatment Environment(s) – Check all that apply since the Date of Case Mgt. Date:

- School-based Services
- Private Outpatient Care
- Emergency Room
- Partial Hospital Program
- Hospital-based Psychiatric Clinic (outpatient)
- Other – Specify: _____
- Community Mental Health Center (CMHC) Outpatient Services
- Intensive Outpatient Program (IOP)
- Mobile Crisis
- Inpatient Unit

Additional Case Management Notes:

Case Managers Printed Name: _____

Case Managers Signature and Date: _____