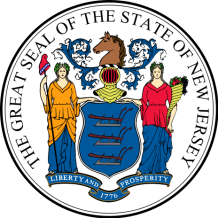
****New Jersey Department of Human Services

Division of Developmental Disabilities

www.nj.gov/humanservices/ddd

**DDD Mental Health Pre-Screening Checklist**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | **Date:** | | | | |
| **DDD#:** | | **Support Coordination Agency:** | | | | | |
| **These questions are to be used to guide discussion with the individual, family, and his/her caregivers about any possible indicators that a mental health evaluation may be necessary. A “yes” response to any of these questions may be an indicator that someone might be experiencing a mental health problem and a further assessment and/or referral to mental health services may be required.** | | | | | | | |
| **Questions** | | | | | | | |
| **Behavioral/Mental Health Changes** | | | | | **Yes** | | **No** |
| 1. Has there been a change in the way that the person reacts/interacts with caregivers? | | | | |  | |  |
| 1. Does the person hurt him/herself or others? | | | | |  | |  |
| 2a. If yes, is this behavior new? | | | | |  | |  |
| 1. Has the person been sleeping more or less than usual? | | | | |  | |  |
| 1. Has there been a significant change in the person’s level of activity? | | | | |  | |  |
| 1. Is the person overly fearful? | | | | |  | |  |
| 5a. If yes, is this behavior new? | | | | |  | |  |
| 1. Does the person seem sadder or appear to be more socially withdrawn than they have in the past? | | | | |  | |  |
| 1. Is the person extremely confused or disoriented? | | | | |  | |  |
| 7a. If yes, is this behavior new? | | | | |  | |  |
| 1. Does the person hear voices even when no one is there? (This is not the same thing as talking to oneself for company or to reduce anxiety.) | | | | |  | |  |
| 8a. If yes, is this behavior new? | | | | |  | |  |
| 1. Does the person have a current or past psychiatric or mental health diagnosis? | | | | |  | |  |
| 9a. Does the person currently take medication for mental health or behavioral  issue(s)? | | | | |  | |  |
| 9b.Is the person currently under treatment with a psychiatrist, APN, primary care physician or another type of mental health therapist? | | | | |  | |  |
| 1. Is there a current behavior plan in place? | | | | |  | |  |
| 1. Has the person ever attempted to commit suicide?   \*If yes, a safety plan is required to be outlined in the ISP | | | | |  | |  |
| 1. Has the person verbalized a desire to commit suicide?   \*Please note, a “yes” will require a direct referral to CARES (**888)393-3007**. | | | | |  | |  |
| **Behavioral/Mental Health Changes Follow up** | | | | | | | |
| Are any of these changes/behaviors interfering with the person’s day to day functioning? | | | | |  | |  |
| Regarding the above questions, mark the box that indicates the type of follow up necessary: | | | | | | | |
|  | Currently being managed with no additional follow-up needed | | | | | | |
|  | Referral to CARES and/or reach out to HMO Care Manager to refer to mental health services | | | | | | |
|  | Revise ISP to address newly identified supports and service needs | | | | | | |
| **Please describe the necessary follow up:** | | | | | | | |
| **Physical/Medical Changes** | | | | **Yes** | | **No** | |
| 1. Has there been a change in the person’s appetite? | | | |  | |  | |
| 1. Has the person gained or lost weight recently? | | | |  | |  | |
| 1. Was the last medical evaluation more than a year ago? | | | |  | |  | |
| 1. Have there been any recent medication changes? | | | |  | |  | |
| 1. Is the person addressing his/her own health and wellbeing needs? | | | |  | |  | |
| 1. Has the person recently been hospitalized for a severe medical condition? | | | |  | |  | |
| **Physical/Medical Changes Follow up** | | | | | | | |
| Are any of these changes interfering with the person’s day to day functioning? | | | |  | |  | |
| Regarding the above questions, mark the box that indicates the type of follow up necessary: | | | | | | | |
|  | Currently being managed with no additional follow-up needed | | | | | | |
|  | Referral to CARES, Medical Doctor, and/or reach out to HMO Care Manager to refer to appropriate mental health/ appropriate services needed | | | | | | |
|  | Revise ISP to address newly identified supports and service needs | | | | | | |
| **Please describe the necessary follow up:** | | | | | | | |
| **Life Circumstance Changes** | | | | **Yes** | | **No** | |
| 1. Has there been any recent change to the person’s environment or life circumstances that appear to be stressful or uncomfortable to them? (Examples: new roommate, death of someone close to them, new staff, etc…) | | | |  | |  | |
| 1. Has the person experienced any traumatic events recently (examples: a car accident, loss of a loved one or caregiver, victim of a crime)? | | | |  | |  | |
| **Life Circumstance Changes Follow up** | | | | | | | |
| Are any of these changes interfering with the person’s day to day functioning? | | | | | | | |
| Regarding the above questions, mark the box that indicates the type of follow up necessary: | | | | | | | |
|  | Currently being managed with no additional follow-up needed | | | | | | |
|  | Referral to CARES and/or reach out to HMO Care Manager to refer to keep services | | | | | | |
|  | Revise ISP to address newly identified supports and service needs | | | | | | |
| Please describe the necessary follow up: | | | | | | | |

*Questions in this Screen were adapted from Juanita St. Croix, Southern Network of Specialized Care, London, Ontario.*

**Additional Comments:**

|  |  |
| --- | --- |
|  |  |
| Support Coordinator (Print) | Signature Date |
|  |  |
| Support Coordinator Supervisor (Print) | Signature Date |