Appendix D: Community Mental Health Program Triage Form

Date of Interview:_____ Clinician:_____

Demographic Information

Name of Youth	
DOB (mm/dd/yr)	
HC #/Expiry date	
Community of Origin	
Cultural Background	
Program of Entry	

Primary Issue of Concern/Reason for Referral (check all that may apply)

❑ Youth Referred ❑ Staff Referred:_____

❑ Emotional Symptoms ❑ Behavioral Symptoms ❑ 3rd Party Letter

❑ Risk Behaviors ❑ Family Mediation ❑ Psychosis

❑ Poor Functioning ❑ Other:_____

Notes

Mental Health History

Diagnosed mental illness(es)	
Previous medications (list name)	
Previous clinical supports	
Emergency visits (date/hospital)	
Inpatient visits (date/hospital)	

Current Treatment

Medication (list):

Name: Dose: When Started (mm/yr):

Name: Dose: When Started (mm/yr):

Medication taken as prescribed?	Y/N:
Family Doctor/Prescribing Physician	
Therapy/Treatment	

Daily Functioning

Meals per day:_____ Hours slept per night:_____

Daily activities: ❑ School ❑ Work ❑ Other:_____

Family/Social Involvement (list people the youth identifies as their social network)

Name	Relationship	Involvement

Notes _____

_____

_____

Substance Use

Alcohol Use: _____ Drug Use: _____

Criminality

Active Charges: ❑ Y ❑ N _____

Probation: _____

Previous YJ Involvement: _____

Risk Behaviors

❑ Self-Harming Behavior: _____

❑ Suicidal Thinking (lifetime, past month, planning, gestures): _____

_____

_____

❑ Other: _____

List identified Strengths/Interests: _____

Summary of Triage _____

_____

_____

_____

GAF Score: _____

Next Steps _____

_____

Checklist (action items)

❑ CANS	❑ Copy of Health Card	❑ PHIPA's
❑ CDI	❑ MASC	❑ Connors
❑ Psychiatry Referral	❑ Family Doctor	❑ Assessment
❑ Skills for Life training	❑ F/U with staff	❑ Safety Plan