



Admission Assessments

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Admission Assessments

In this lesson you will complete the admission assessment. You will learn the four assessment pieces that are attached to the main assessment window to form a complete, comprehensive assessment.

Lesson Objectives

- Understand the Admission Assessment window for both Adult and Youth
- Use the five windows that together make up a complete Admission Assessment
 - Adult / Child-Youth Admission Assessment
 - LOCUS/CALOCUS
 - Mental Status Exam (ADULT+PIN) / Mental Status/Behavioral Observation (YOUTH)
 - Substance Use
 - BHRS Diagnosis
- Use the ADULT or CHILD/YOUTH Special Assessment for clients returning to the same episode

LESSON SCENARIO

Adam Apple comes to the clinic to be assessed by the clinician assigned to him by the admitting program. The clinician meets with Adam during several sessions and completes (within 60 days) all the windows that make up the complete adult admission assessment: Admission Assessment, Mental Status and Behavioral Observation, LOCUS/CALOCUS, Substance Use Assessment, and Diagnosis. Until the full assessment is complete, the clinician sees an item in the Avatar To-Do list as a reminder to complete the assessment before the due date.

The Finalize tab of the Admission Assessment is where the clinician attaches the four other pieces of the assessments, completed within the last 60 days, to the admission assessment.

AVPMCONV (LIVE) - OREGANO, OLIVER (000930098) ADULT Admission Assessment

File Edit Favorites Avatar PM Avatar CWS Avatar M50 Help

Page 1 of 1

OREGANO, OLIVER (000930098) Episode: 2 Date Of Birth: 08/13/1964; Sex: Male

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation **Finalize**

Identifying Information Presenting Problems Co-Occurring Issues Risk Assessment Client Strengths Psychosocial History

Specify ASSESSMENT TOOLS that belong to THIS ASSESSMENT *Must be completed before FINALIZING this assessment*

MENTAL STATUS EXAM for this assessment Aug 25 2010 -JILL MURPHY	LOCUS Rating for this assessment Aug 25 2010 -JILL MURPHY
SUBSTANCE USE SCREENING for this assessment Aug 25 2010 -JILL MURPHY	DIAGNOSIS for this assessment Aug 25 2010 -JILL MURPHY

Indicate other persons contributing to this assessment

Contributing Practitioner [Text Field] [Process Search] [Dropdown]

Contributing Practitioner [Text Field] [Process Search] [Dropdown]

Draft/Pending Approval/Final
 Draft Final Pending Approval

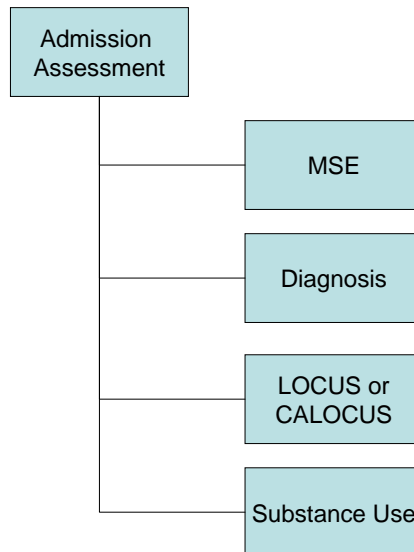
Send To [Dropdown]
Send To Outgoing Comments [Text Field]

UNDERSTANDING THE ADMISSION ASSESSMENT

The admission assessment is designed to provide a comprehensive clinical picture of the client and to establish medical necessity. This helps treatment teams and clients define problems, goals, objectives, and interventions. It also fulfills State and Federal requirements.

Assessments can only be performed for a client who has been admitted to an episode. There are five pieces that go together to make up a complete assessment:

- ADULT or CHILD/YOUTH Admission Assessment
- Mental Status Exam (ADULT+PIN) or Mental Status/Behavioral Observation (YOUTH)
- BHRS Diagnosis
- LOCUS or CALOCUS
- Substance Use Assessment (not required if no substance use is indicated in the admission assessment)



IMPORTANT

You must complete and submit each of these pieces as final within the last 60 days in order to finalize the admission assessment. If even one piece is not yet submitted as final, you will have to save the admission assessment as a draft, complete the missing piece then return to the admission assessment to submit it as final.

TIP! For Quality Management (QM)-guided assistance in completing any free text field, click the Help lightbulb icon next to the field.

UNDERSTANDING THE ADULT ADMISSION ASSESSMENT

Avatar’s assessment features assists a clinician in determining what level of care is appropriate for a client, assessing immediate risks and collecting information about the clients personal and social circumstances.

Although the Adult and Child-Youth assessments follow the same general structure and workflow, there are a few fundamental differences. For example, the adult assessment includes a LOCUS while the child-youth assessment includes a CALOCUS.

WHO CAN PERFORM THIS FUNCTION?

Any clinical staff member who is assessing the client can perform this function.

MENU PATH

Avatar CWS→Assessments→ADULT Admission Assessment

IDENTIFYING INFORMATION TAB PAGE 1 (ASSESSMENT INFO)

Use this page to document the date and source of the contact regarding the client. This page also includes a button that allows you to review the client’s ICI information.

The screenshot shows the 'Identifying Information' tab in the software. The 'Assessment Date' is 04/27/2010. The 'Referral Source' is ACCESS. The 'Referral Contact Information' field is empty. The 'Name Client Prefers to Use' is ADAM. The 'Date of Birth' is 03/01/1980. The 'Client Age' is 30. A 'VIEW ICI' button is located below the 'Source of Information' section. A red 'A' points to this button, and a red 'B' points to the 'Client Age' field.

Field/Button	Description
A) View ICI	Clicking this button generates a report that displays all the information from the client’s Initial Contact Screening (ICI).
B) Client Age	Client age does not auto-calculate; you must enter it manually.

IDENTIFYING INFORMATION TAB PAGE 2 (LANGUAGE INFORMATION)

Use this page to document the client's primary and preferred language, and whether a translator was needed.

IDENTIFYING INFORMATION TAB PAGE 3 (CSI INFORMATION)

All fields on this page are required. Use this page to document the client's employment and education status, and to record education information for California State tracking purposes.

Field/Button	Description
A) Number of children under the age of 18 the client cares for...	If you are unable to assess the number of children or adults the client cares for at least 50% of the time, type 99 in that field.



Exercise 1 Complete the Identifying Information Tab

In this exercise you will review the client's ICI information and enter the client's identifying information. **Before You Begin:** Select a sample client you are working with using the Select Client icon on the Task Bar. In this example the client is Adam Apple.


1. Choose Avatar CWS→Assessments→ADULT Admission Assessment from the Menu Frame.
2. Follow these steps to enter the client's data in the Assessment Info tab:

A Click the View ICI button. When Avatar asks if you want to download the report, click Yes.

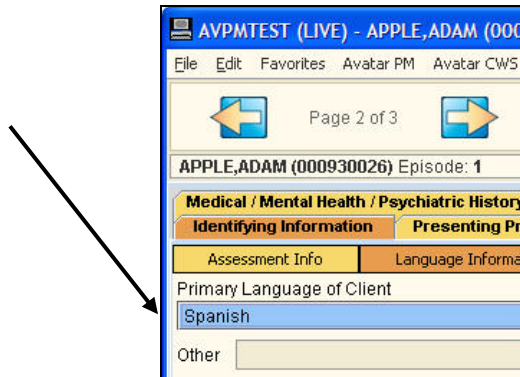
Review the report then click the red Close button in the upper-right corner of the window to close it.


B Check Client Interview and Previous Records.

C Enter the client's age.

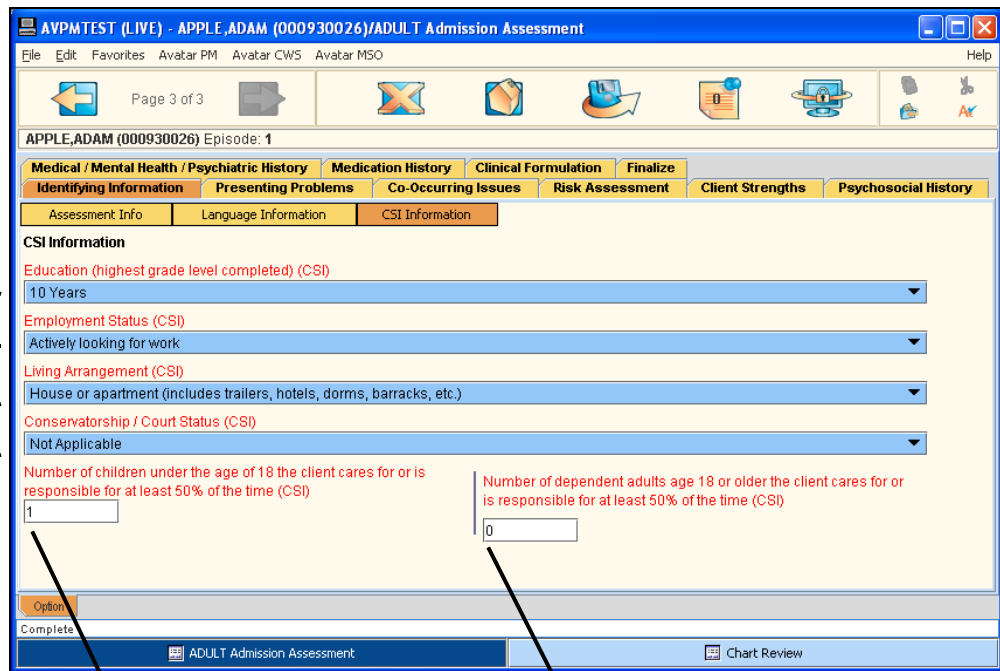
3. Click the Forward  icon on the Option toolbar to go to page 2.

- Select Spanish in the Primary Language of Client dropdown list.



- Click the Forward  icon on the Option toolbar to go to page 3.
- Follow these steps to complete the CSI information:

- A Select 10 Years.
- B Select Actively Looking for Work.
- C Select House or Apartment.
- D Select Not Applicable.



E Enter 1 in this field.

F Enter 0 in this field.

Leave this window open for the next exercise.



PRESENTING PROBLEMS TAB

As noted at the bottom of this tab, make sure to include information regarding the impact of substance use and/or trauma on presenting problems. All fields on this tab are required.

AVPMTEST (LIVE) - APPLE, ADAM (000930026)/ADULT Admission Assessment

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Page 1 of 1

APPLE,ADAM (000930026) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information **Presenting Problems** Co-Occurring Issues Risk Assessment Client Strengths Psychosocial History

Description of Current Presenting Problems (incl. referral reason, symptoms, behaviors, and impairments)

Mental Health History (incl. onset, severity, and other changes)

*** Include information regarding the impact of SUBSTANCE USE and/or TRAUMA on Presenting Problem ***

Option

Complete

ADULT Admission Assessment Chart Review

CO-OCCURRING ISSUES TAB PAGE 1 (SUBSTANCE USE)

Document any substance use issues here.

AVPMTEST (LIVE) - APPLE, ADAM (000930026)/ADULT Admission Assessment

Page 1 of 2

APPLE, ADAM (000930026) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information Presenting Problems **Co-Occurring Issues** Risk Assessment Client Strengths Psychosocial History

Substance Use Trauma

Substance Use Issues Impacting Client (select 1 or more)

Current Substance Abuse Past Substance Abuse History

Use impacts Functioning/Presenting Prob Abuse / Misuse of OTC Medications

Abuse / Misuse of Prescription Drugs Use of Illicit Drugs

Abuse / Misuse of Caffeine Abuse / Misuse of Nicotine

None Other

Unknown

Other

*** Document Substance Use Issues on SUBSTANCE USE ASSESSMENT ***

Option

Complete

ADULT Admission Assessment Chart Review

Field	Description
A) Substance Use Issues	If you answer None on the Co-Occurring tab, it grays out the Substance Use assessment dropdown list on the Finalize tab. If you indicate Nicotine or Caffeine on the Co-Occurring tab, it makes the Substance Use dropdown list optional. Anything else makes the dropdown list required.

CO-OCCURRING ISSUES TAB PAGE 2 (TRAUMA HISTORY)

Document trauma history and related details on this page

RISK ASSESSMENT TAB PAGE 1

All fields are required on this page. If the client is negative for all elements click No, Denied, Undetermined, or Unknown for each entry.



Exercise 2 Complete Presenting Problems and Risk Assessment Tabs

In this exercise you will document the client's presenting problems, co-occurring issues, and risk assessment.

Before You Begin: The ADULT Admission Assessment window should still be open from the last exercise.

1. Go to the Presenting Problems tab.
2. Enter the information shown in the two text boxes.

AVPMTEST (LIVE) - APPLE, ADAM (000930026)/ADULT Admission Assessment

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Page 1 of 1

APPLE, ADAM (000930026) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information Presenting Problems Co-Occurring Issues Risk Assessment Client Strengths Psychosocial History

Description of Current Presenting Problems (incl. referral reason, symptoms, behaviors, and impairments)

Depression, insomnia, lack of interest in social contact.

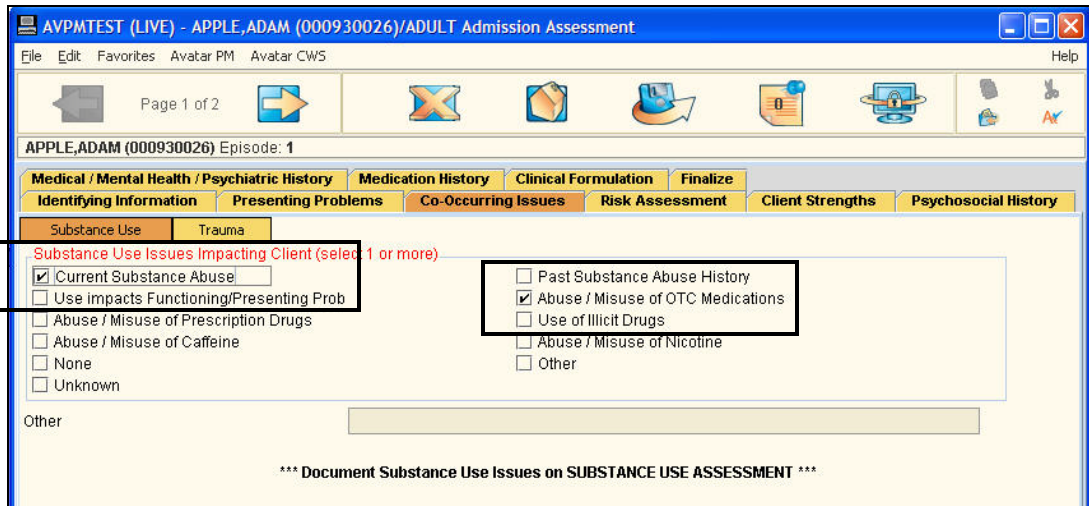
Mental Health History (incl. onset, severity, and other changes)


Previous therapy with BHR\$ 10 years ago.

*** Include information regarding the impact of SUBSTANCE USE and/or TRAUMA on Presenting Problem ***

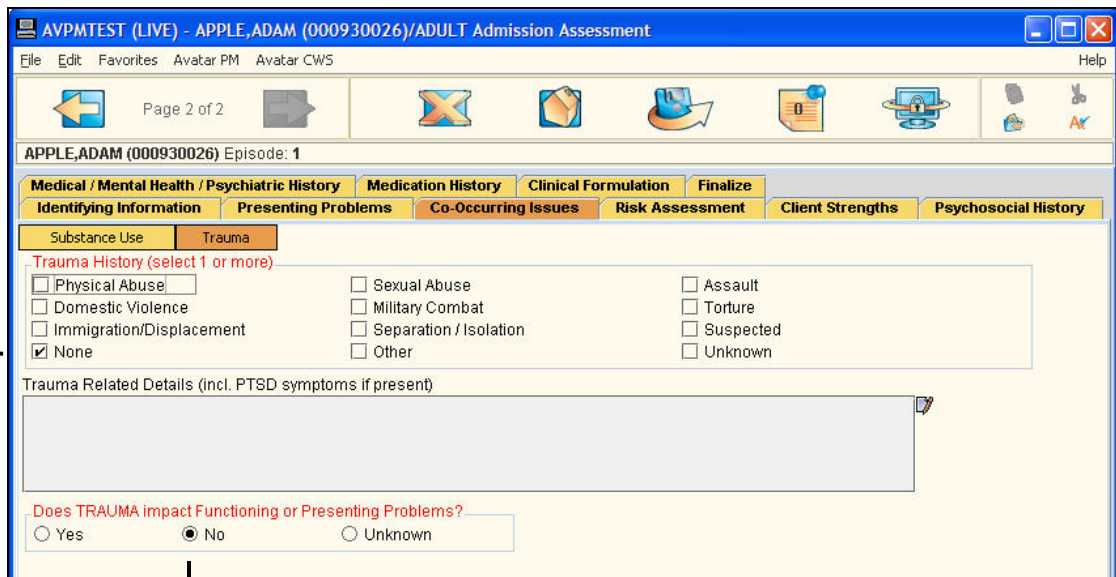
3. Go to the Co-Occurring Issues tab.

4. Check the checkboxes shown in the following illustration.



5. Click the Forward  icon on the Option toolbar to go to page 2.
6. Follow these steps to complete page 2 of the Co-Occurring Issues tab:

A Click the None checkbox.



B Click the No option.

7. Click the Risk Assessment tab.

8. Follow these steps to complete the Risk Assessment tab:

A Choose Yes in this field.

B Choose Denied in these fields.

C Choose No in these fields.

D Select No for all of these factors.

The screenshot shows the following fields and their selected options:

- Risk of HARM TO SELF/SUICIDAL Thoughts/Behavior:** Yes
- Current HARM TO OTHERS/HOMICIDAL Thoughts:** Yes, Denied, Undetermined
- Access to FIREARMS / WEAPONS:** Yes, Denied, Undetermined
- Current Domestic Violence Issues:** Yes, No, Unknown
- Engaged in Violent Acts? (physical, sexual, vandalism):** Yes, No, Unknown
- Past HARM TO SELF/SUICIDAL Thoughts/Behavior:** Yes, No, Unknown
- Past HARM TO OTHERS/HOMICIDAL Thoughts:** Yes, No, Unknown
- Does SUBSTANCE USE impact risk?:** Yes, No, Unknown
- Past Domestic Violence Issues:** Yes, No, Unknown
- Victim of Violence?:** Yes, No, Unknown

Leave this window open for the next exercise.



CLIENT STRENGTHS TAB

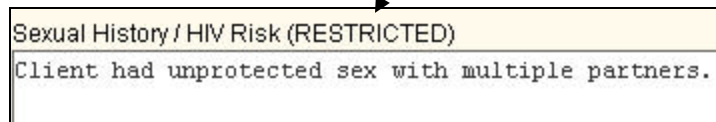
Use this tab to document client strengths/assets/positive coping skills and sources of support in the life of the client.

PSYCHOSOCIAL HISTORY TAB PAGE 1

The first page of the Psychosocial History tab focuses on developmental issues, cultural background, and sexual orientation and identification. Because gender and sexual orientation are already addressed in the two option lists for gender and sexual orientation, it is only necessary to comment further on gender and sexual orientation in the Cultural/Spiritual/Lifestyle Background text field if you need to provide additional detail on these questions.

PSYCHOSOCIAL HISTORY TAB PAGE 2

Document the client's social, educational, employment, sexual, and criminal justice history on this page. When you see RESTRICTED next to a text field, this information will not print to any reports, including a printout of the assessment.



Sexual History / HIV Risk (RESTRICTED)
Client had unprotected sex with multiple partners.



Exercise 3 Document Client Strengths and Psychosocial History

In this exercise you will complete the Client Strengths and Psychosocial History tabs.

Before You Begin: The ADULT Admission Assessment window should still be open from the last exercise.

1. Go to the Client Strengths tab.
2. Enter the information in the text fields as shown in the following figure and check Family and Friend in the Sources of Support area.

AVPMTEST (LIVE) - APPLE, ADAM (000930026)/ADULT Admission Assessment

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APPLE, ADAM (000930026) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information Presenting Problems Co-Occurring Issues Risk Assessment **Client Strengths** Psychosocial History

Client's Strengths / Assets / Positive Coping Skills

Client is concerned about his functioning and wants things to be different. He appears to be aware that he is uncomfortable and "unhappy."

Sources of Support

Family Neighbor Friend

Church School Work

Community Organization Professional Provider Other

Sources of Support Details

Wife and daughter are aware of his problems and are supportive. A close friend has been trying to get him to do volunteer work.

Highest Level of Functioning (what was different or contributed that functioning level)

He functioned at a higher level prior to the need to assist his father who is elderly and has dementia.


Option

Complete

ADULT Admission Assessment Chart Review

3. Go to the Psychosocial History tab.

- Enter the information in the text boxes and make the choices in the lists shown in the following illustration:

- Click the Forward  icon on the Option toolbar to move to page 2.
- Enter the text in the Social Activities/Relationships/Interests text box shown here.

Leave the ADULT Admission Assessment window open for the next exercise.



MEDICAL/MENTAL HEALTH/PSYCHIATRIC HISTORY TAB

Medical, mental health, and family history are documented on this tab. Note that specific medication history is documented on the Medication History tab.

MEDICATION HISTORY TAB

This page allows you to document the medication history of a client. For detailed information on how to add, edit, or delete items from a multiple entry table, see Lesson 6 in the *Introduction to Avatar* manual.

AVPMTEST (LIVE) - APPLE,ADAM (000930026)/ADULT Admission Assessment

Page 1 of 1

APPLE,ADAM (000930026) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information Presenting Problems Co-Occurring Issues Risk Assessment Client Strengths Psychosocial History

Medication History (Prescription and OTC by client report)

Medication Name	Dosage / Frequency	Currently Prescribed?	Date of Initial Prescription	Prescribing M.D.	Purpose of Medication	Me
ATIVAN	.5mg 2X/DAILY	Yes	APRIL 2007	SMITH	ANXIETY	Co

Add New Item Edit Selected Item Delete Selected Item

Medication Name: ATIVAN
Dosage / Frequency: .5mg 2X/DAILY
Currently Prescribed?: Yes No
Date of Initial Prescription: APRIL 2007
Prescribing M.D.: SMITH

Purpose of Medication: ANXIETY
Medication Compliance: Compliant Partially Compliant Not Compliant Unknown
Response / Adverse Reaction / Side Effects / Allergy: DROWSINESS
Estimated Refill Need: UNKNOWN

Option: Complete

ADULT Admission Assessment Chart Review

CLINICAL FORMULATION TAB PAGE 1 (FORMULATION)

Use this page to document the areas treatment address and the clinical formulation.

FINALIZE TAB

Use this tab to attach previously completed assessments to the main Admission Assessment.



IMPORTANT

If any of the assessment dropdown lists on this page are empty, it means that the specific assessment has not been completed in the last 60 days. To correct this so that the assessment can be submitted as Final, you must save this Admission Assessment window as a Draft, then open and complete the missing assessment, and save it as Final. You can then re-open the Admission Assessment window in order to see the assessment dropdown lists populate with Clinician Name and Date for any assessment completed within the last 60 days.

If you selected None for the ALCOHOL and/or DRUG USE on the Co-Occurring Issues tab, the Substance Use assessment is no longer required on this page.

Field	Description
A) Send To	Licensed clinical staff members typically do not use this field. If you are an intern or need manager approval for this assessment, the list of BHRS staff members in this field is populated with the colleagues you are likely to work with, including those who would approve your assessments. If you need to add a person, contact the ISD Department.

Field	Description
B) Send To Outgoing Comments	Licensed clinical staff members typically do not use this field. If you are an intern or need manager approval for this assessment, provide any comments you have here for the BHRS staff member you're sending this assessment to.



Exercise 4

Complete the Medical/Mental Health/Psychiatric History, Medication History, Clinical Formulation, and Finalize Tabs

In this exercise you will enter the client information for four of the assessment tabs.

Before You Begin: The ADULT Admission Assessment window should still be open from the last exercise.

1. Switch to the Medical/Mental Health/Psychiatric History tab.
2. Enter the information shown in the text boxes in the following illustration.

AVPMTEST (LIVE) - APPLE,ADAM (000930026)/ADULT Admission Assessment

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APPLE,ADAM (000930026) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information Presenting Problems Co-Occurring Issues Risk Assessment Client Strengths Psychosocial History

Psychiatric Hospitalization / Partial Hospitalization History / Residential (incl. provider and dates)

Outpatient Treatment History (incl. providers and dates; therapeutic interventions and responses)
Previously treated at outpatient clinic in Central County in 2000. Received individual therapy and medication.

Physical Medical History / Significant Illnesses / Chronic Conditions / Surgeries / Allergies
Allergic to Penicillin, Hx of Graves Disease at age 40. No surgeries.

Family Medical / Mental Health History
No known mental health history of other family members. Father has dementia. Mother had unknown thyroid disease.

Option

Complete

ADULT Admission Assessment Chart Review

3. Go to the Medication History tab.

4. Follow these steps to complete the Medication History:

A Click the Add New Item button to create a new yellow row in the multiple entry table.

The screenshot displays the AVPMTEST (LIVE) application window for patient APPLE, ADAM (000930026). The 'Medication History' tab is selected, showing a table with the following data:

Medication Name	Dosage / Frequency	Currently Prescribed?	Date of Initial Prescription	Prescribing M.D.	Purpose of Medication	Me
PROZAC	10 MGM QD	No	2000	DR. SMITH	DEPRESSION	Cot

Below the table, the 'Add New Item' button is highlighted. A detailed form for the new item is shown below the table, with the following fields:

- Medication Name: PROZAC
- Dosage / Frequency: 10 MGM QD
- Currently Prescribed?: Yes No
- Date of Initial Prescription: 2000
- Prescribing M.D.: DR. SMITH
- Purpose of Medication: DEPRESSION
- Medication Compliance: Compliant Partially Compliant Not Compliant Unknown
- Response / Adverse Reaction / Side Effects / Allergy: NOT EFFECTIVE
- Estimated Refill Need: UNKNOWN

B Enter the information in the text fields as shown here, and choose No in the Currently Prescribed area and Compliant in the Medication Compliance field.

Notice that data appears in the multiple entry table as you enter it here.


5. Go to the Clinical Formulation tab.

6. Check School/Work Functioning, Symptom Management, and Daily Living Skills. Enter a Clinical Formulation/Summary in the text box.

7. Go to the Finalize tab.
8. Check the dropdown boxes for each of the four assessments to see if any assessments have been completed in the last 60 days.

Because we haven't completed any other pieces of the assessment within the last 60 days, all of the dropdown lists are empty.

Remember that you must complete all required assessments before you can finalize the main Admission Assessment.

9. Verify that Draft is selected.
10. Click the Submit  icon to save what you completed so far as a Draft.



UNDERSTANDING THE CHILD/YOUTH ADMISSION ASSESSMENT WINDOW

Many of the screens in the Child/Youth Admission Assessment are the same as the Adult Admission Assessment.

NOTE: If you need to admit a Child/Youth into BHRS, follow steps in the Quick Reference Guide—Admission Assessments (Adult, Child/Youth, and Pre-3).

There are some differences which are explained on the next few pages.

WHO CAN PERFORM THIS FUNCTION?

Any clinical staff member who is assessing the client can perform this function.

MENU PATH

Avatar CWS→Assessments→CHILD/YOUTH Admission Assessment

IDENTIFYING INFORMATION TAB PAGE 1 (ASSESSMENT INFO)

Use this page to collect basic identifying information, such as assessment type and sources of information.

Field/Button	Description
A) Assessment Type	<p>26.5: For clients who have been referred for Mental Health assessment from a school district (must be authorized prior to assessment).</p> <p>Change in Level of Care: Client is being reassessed for purposes of changing level of care (e.g. Outpatient to Residential).</p> <p>Outpatient Mental Health: Standard Mental Health Assessment for Youth.</p>

IDENTIFYING INFORMATION TAB PAGE 2 (SPECIAL ED AND LEGAL STATUS)

Use this page to document special education eligibility and legal status.

IDENTIFYING INFORMATION TAB PAGE 3 (LANGUAGE INFORMATION)

Document the primary and preferred languages of the client and the client's family on this page, as well as whether language services were offered.

IDENTIFYING INFORMATION TAB PAGE 4 (CSI INFO)

All CSI information on this page is required. Document highest grade completed, employment status, living arrangement, conservatorship/court status, and number of children and/or dependent adults the client cares for at least 50% of the time.

PRESENTING PROBLEMS TAB

As stated at the bottom of this tab, indicate if trauma or substance use impacts the presenting problem. Document the description of the presenting problems, behavioral/mental health history, and current/past living situation on this tab.

CO-OCCURRING ISSUES TAB PAGE 1 (SUBSTANCE USE)

Like the adult assessment, this tab directly controls whether a substance use assessment is necessary. Selecting None disables the substance use assessment on the Finalize tab. Making choices such as caffeine or nicotine makes the substance use assessment optional on the Finalize tab. Selecting boxes such as those checked in the picture below makes the Substance Use Screening assessment required.

AYPMCONV (LIVE) - TULIP, TED (000930039)/CHILD / YOUTH Admission Assessment

File Edit Favorites Avatar PM Avatar CWS Avatar MSO Help

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TULIP, TED (000930039) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information Presenting Problems **Co-Occurring Issues** Risk Assessment Client Strengths Psychosocial History

Substance Use Trauma History

SUBSTANCE USE Issues Known to Impact Client

Current Substance Abuse Past Substance Abuse

Use Impacts Functioning/Presenting Prob Use of Illicit Drugs

Abuse/Misuse of OTC Medications Abuse/Misuse of Prescription Drugs

Abuse/Misuse of Caffeine Abuse/Misuse of Nicotine

Current Subs. Use in Parents/Cargivers Past Subs. Abuse in Parents/Caregivers

Missed School or Impaired by Use Family is concerned by Alcohol/Drug Use

None Other

Unknown

Other

*** Document Substance Use Issues on the SUBSTANCE USE ASSESSMENT ***

CO-OCCURRING ISSUES TAB PAGE 2 (TRAUMA HISTORY)

Document any client or family trauma on this page. All fields except the Child/Family Trauma Related Details field are required.

RISK ASSESSMENT TAB

All fields on this page are required except the Risk and Violence Details field.

CLIENT STRENGTHS TAB

Document client's and client's family strengths and sources of support on this tab.

PSYCHOSOCIAL HISTORY TAB PAGE 1

Record the client's developmental and acculturation history as well as gender identity/sexual orientation information on this page.

PSYCHOSOCIAL HISTORY TAB PAGE 2

Because gender identity and sexual orientation are addressed on the previous page, it is only necessary to comment further in the cultural/spiritual/lifestyle background text field about gender or sexual orientation if you need to provide more detail.

Also use this page to document social activities/relationships (including gang affiliation), education, and juvenile justice history.

MEDICAL/MENTAL HEALTH/PSYCHIATRIC HISTORY TAB PAGE 1

Document any hospitalization/residential placement, outpatient treatment, and medical/illness history on this page.

MEDICAL/MENTAL HEALTH/PSYCHIATRIC HISTORY TAB PAGE 2

Record any client allergies and encopresis/enuresis status on this page.

MEDICATION HISTORY TAB

Record the client's medication history on this tab. For more detail on how to work with a multiple entry table, see Lesson 6 in the *Introduction to Avatar* manual.

The screenshot displays the Avatar software interface for a client named TULIP, TED (000930039). The window title is "AVPMCONV (LIVE) - TULIP, TED (000930039)/CHILD / YOUTH Admission Assessment". The interface includes a menu bar (File, Edit, Favorites, Avatar PM, Avatar CW5, Avatar MSO) and a toolbar with various icons. The main content area is titled "TULIP, TED (000930039) Episode: 1" and features a tabbed interface with the following tabs: "Medical / Mental Health / Psychiatric History", "Medication History", "Clinical Formulation", "Finalize", "Identifying Information", "Presenting Problems", "Co-Occurring Issues", "Risk Assessment", "Client Strengths", and "Psychosocial History". The "Medication History" tab is active, showing a table titled "Medication History (Prescription and OTC by client)".

Medication Name	Dosage / Frequency	Prescribing M.D. / Location	Purpose of medication	Currently prescribed?	Response / Adverse
RITALIN	1 MG 2X/DAILY	SPENCER/SAN MATEO	ADD	Yes	INSOMNIA

Below the table are three buttons: "Add New Item", "Edit Selected Item", and "Delete Selected Item". The form below the table includes the following fields:

- Medication Name: RITALIN
- Dosage / Frequency: 1 MG 2X/DAILY
- Prescribing M.D. / Location: SPENCER/SAN MATEO
- Purpose of medication: ADD
- Currently prescribed?: Yes No Unknown
- Response / Adverse Reaction / Side Effects / Allergy: INSOMNIA
- Date of Initial Prescription: MARCH 2008
- Estimated refill need/ # of pills left: [Empty field]
- Medication Compliance: Compliant (dropdown menu)

At the bottom of the form, there is an "Option" section with a "Complete" button. The status bar at the bottom of the window shows "CHILD / YOUTH Admission Assessment" and "Chart Review".

CLINICAL FORMULATION TAB PAGE 1 (FORMULATION)

Formulate what the client, the client's family, or the school sees as a successful outcome of treatment. You can also record risk evaluation details and the client's state of change status.

CLINICAL FORMULATION TAB PAGE 2 (FORMULATION)

This page is used to document impairments based on the primary diagnosis, as well as the clinical formulation. All fields on this page are required.

CLINICAL FORMULATION TAB PAGE 3 (IEP RECOMMENDATIONS)

Document 26.5 eligibility, IEP summary and recommendations, and service needs on this page.

AVPMCONV (LIVE) - TULIP, TED (000930039)/CHILD / YOUTH Admission Assessment

Page 3 of 3

TULIP, TED (000930039) Episode: 1

Medical / Mental Health / Psychiatric History Medication History Clinical Formulation Finalize

Identifying Information Presenting Problems Co-Occurring Issues Risk Assessment Client Strengths Psychosocial History

Formulation (Page 1) Formulation (Page 2) IEP Recommendations

A 26.5 Eligible?
 Yes No

B 26.5 I.E.P. Summary and Recommendations (I.E.P. Report)

Field	Description
A) 26.5 Eligible?	This field only becomes available if you select 26.5 for the assessment type on the Identifying Information tab.
B) 26.5 I.E.P. Summary and Recommendations	This field only becomes available if you select 26.5 for the assessment type on the Identifying Information tab.

FINALIZE TAB

Use this tab to attach the other previously completed assessments to the overall Admission Assessment.



IMPORTANT

If any of the assessment dropdown lists on this page are empty, this means that the specific assessment has not been completed in the last 60 days. To correct this so that the assessment can be submitted as Final, you must save this Admission Assessment window as a Draft then open and complete and finalize the Mental Status and Behavioral Observation, Substance Use, LOCUS, or Diagnosis windows. You can then re-open this Admission Assessment window in order to see the assessment dropdown lists populate with Clinician Name and Date for any assessment completed within the last 60 days.

Choices you make on the Co-Occurring Issues tab determine whether or not the Substance Use Screening field is unavailable, optional, or required.

Field	Description
A) Send To	If you are an intern or need manager approval for this assessment, the list of BHRS staff members in this field is populated with the colleagues you are likely to work with including those who would approve your assessments. If you need to add a person, contact the ISD Department.
B) Send To Outgoing Comments	If you are an intern or need manager approval for this assessment, enter any comments you have for the BHRS staff member you're sending this assessment to.

UNDERSTANDING THE ADULT OR CHILD/YOUTH SPECIAL ASSESSMENT WINDOW

The Special Assessment is primarily used by the Interface Team. It is also used when a client returns to the County from an outside contractor, or when the client returns less than 1 year from last discharge.

Many of the screens in this window are the same as the adult or youth assessments, but it is not as comprehensive as a full admission assessment. The highlights are explained below.

WHO CAN PERFORM THIS FUNCTION?

Any clinical staff member who is assessing the client can perform this function.

MENU PATH

Avatar CWS→Assessments→ADULT Special Assessment

Avatar CWS→Assessments→CHILD/YOUTH Special Assessment

CURRENT CLINICAL INFORMATION TAB PAGE 3 (CO-OCCURRING ISSUES)

How you answer the Substance Use Issues field controls whether or not a substance use assessment is required or not. If you answer None, Substance Use becomes deactivated on the Finalize tab. If you answer yes to Nicotine or Caffeine abuse, Substance Use becomes an optional field. If you answer yes to any other Substance Use Issue, Substance Use becomes required on the Finalize tab.

FINALIZE TAB

The Finalize tab in this assessment works exactly as it does in an ADULT or CHILD/YOUTH Admission Assessment. See the Finalize tab section for those assessments for details.

UNDERSTANDING THE LOCUS WINDOW

The Levels of Care Utilization System (LOCUS) is used by BHRS as treatment planning and utilization management tools. Scores on the LOCUS are based on the clinical needs of clients and help ensure that clients receive the types and amount of services that correspond to the clinical need.

WHO CAN PERFORM THIS FUNCTION?

Only clinical staff can perform this function.

MENU PATH

Avatar CWS→Assessments→LOCUS

ADULT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 1

Score the client's risk of harm on this page.

TIP! For any of the pages in this tab, click the Help lightbulb icon for QM guidance on how to score the LOCUS.

AVPMTEST (LIVE) - APPLE, ADAM (000930021) LOCUS

File Edit Favorites Avatar PM Avatar CWS Help

Page 1 of 6

APPLE, ADAM (000930021)

Adult Level of Care Utilization System Finalize

I. Risk of Harm

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past.

FOR DIMENSION RATING SCALE CLICK ON LIGHT BULB

#1 - Risk of Harm

1-Minimal Risk 2-Low risk 3-Moderate Risk 4-Serious risk 5-Extreme Risk

Option

Complete LOCUS Chart Review

ADULT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 2

Score the client's functional status on this page.

ADULT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 3

Score the client's medical, addictive, and psychiatric co-morbidity on this page.

ADULT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 4

Score the client's recovery environment on this page.

ADULT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 5

Score the client's treatment and recovery history on this page.

ADULT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 6

Score the client's recovery and engagement status on this page.

AVPMCONV (LIVE) - APPLE,ADAM (000930026)/LOCUS

File Edit Favorites Avatar PM Avatar CWS Help

Page 6 of 6

APPLE,ADAM (000930026)

Adult Level of Care Utilization System Finalize

VI. Recovery and Engagement Status

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension. These factors will likewise impact a person's ability to be successful at a given level of care.

FOR DIMENSION RATING SCALE CLICK ON LIGHT BULB

#6 - Engagement

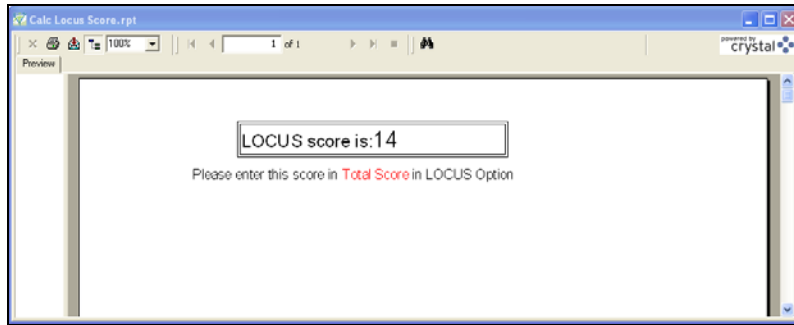
1-Optimal 2-Positive 3-Limited 4-Minimal 5-Unengaged

Calculate Score Total Score 14

Option Complete

LOCUS Chart Review

After choosing an option in the Engagement field, click the Calculate Score button to generate a report that calculates the Total Score as shown in the following figure. Type this number in the Total Score field.



FINALIZE TAB

Use this tab to submit the information as a Draft or Final. If you are an intern and need to get manager approval for this assessment, you have the option to select Pending Approval and designate a staff member to send the assessment to for review and provide outgoing comments.

Draft / Pending Approval / Final	
<input checked="" type="radio"/> Draft	<input type="radio"/> Final
<input type="radio"/> Pending Approval	
	Send To
	<input type="text"/>
	Send To Outgoing Comments
	<input type="text"/>








Exercise 6 Write a LOCUS Assessment

In this exercise you will complete a LOCUS assessment.

Before You Begin: Select a sample client you are working with using the Select Client icon. In this example the client is Adam Apple.

1. Choose Avatar CWS→Assessments→LOCUS from the Menu Frame.
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new LOCUS assessment.
3. Choose Moderate Risk in the Risk of Harm field, as shown here.

The screenshot shows a web browser window titled 'AVPMTEST (SAMPLE) - APPLE, ADAM (000000390)/LOCUS'. The browser's address bar and menu bar are visible. Below the browser window, there is a toolbar with several icons. The main content area displays the client's name 'APPLE, ADAM (000000390)' and some personal information. A section titled 'Adult Level of Care Utilization System' has a 'Finalize' button. Below that, the 'I. Risk of Harm' section is shown with five radio button options: '1-Minimal Risk', '2-Low risk', '3-Moderate Risk', '4-Serious risk', and '5-Extreme Risk'. The '3-Moderate Risk' option is selected, and an arrow points to it from the text above.


4. Click the Forward  icon on the Option toolbar to move to page 2.
5. In the Functional Status field, Select 3-Moderate.
6. Click the Forward  icon on the Option toolbar to move to page 3.
7. In the Medical, Addictive and Psychiatric Co-Morbidity field, choose 2-Minor.
8. Click the Forward  icon on the Option toolbar to move to page 4.
9. Select 4-Highly in the Environmental Stressors field and 2-Supportive in the Environmental Support fields.
10. Click the Forward  icon on the Option toolbar to move to page 5.
11. Choose 3-Moderate/Equivocal in the Treatment and Recover History field.
12. Click the Forward  icon on the Option toolbar to move to page 6.
13. Choose 2-Positive in the Engagement field.

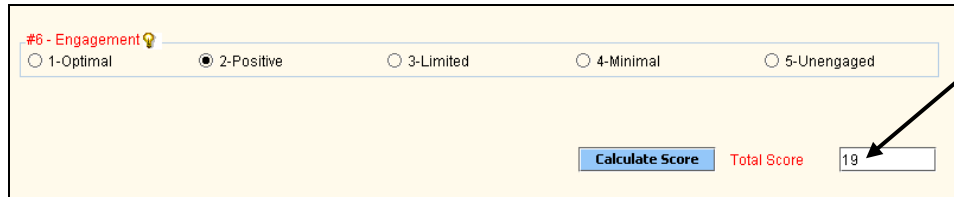
Next you will generate a report that calculates the LOCUS score and you'll enter the score in the LOCUS window.

14. Click the Calculate Score button.

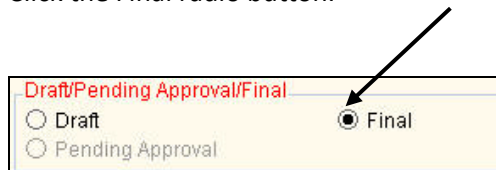
The screenshot shows a section of the LOCUS assessment interface titled '#6 - Engagement'. It contains five radio button options: '1-Optimal', '2-Positive', '3-Limited', '4-Minimal', and '5-Unengaged'. The '2-Positive' option is selected. Below the options is a blue button labeled 'Calculate Score'. To the right of the button is a text field labeled 'Total Score' containing the number '19'. An arrow points from the text above to the 'Calculate Score' button.


Avatar asks if you want to download the report.

15. Click OK to download the report.
The score that appears in the report window.
16. Click the Close  button in the upper-right corner of the report window.
17. In the Total Score field, type the number from the report window. (If you used the scoring indicated in the exercise, it should be 19.)



18. Click the Finalize tab.
19. Click the Final radio button.



20. When the message appears indicating that selecting Final prevents future edits, click OK.
21. Click the Submit  icon on the Option toolbar to save your work.



UNDERSTANDING THE CALOCUS WINDOW

BHRS uses the Child and Adolescent Levels of Care Utilization System (CALOCUS) as a treatment planning and utilization management tool. The clinical needs of clients are the basis of the scores on the CALOCUS and this helps ensure that clients receive the types and number of services that correspond to their clinical needs. This tool is now an important part of our system and it is integrated into the timeline structure of important clinical documents. In addition, the CALOCUS is useful in authorizing day treatment services.

TIP! For any the CALOCUS pages, click the Help lightbulb icon for QM guidance on how to score the CALOCUS.

WHO CAN PERFORM THIS FUNCTION?

Only clinical staff members can perform this function.

MENU PATH

Avatar CWS→Assessments→CALOCUS

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 1

Score the client's risk of harm on this page.

The screenshot shows the CALOCUS software interface for a client named BELLFLOWER, BERT (000930128). The window title is "AVPMCONV (LIVE) - BELLFLOWER, BERT (000930128)/CALOCUS". The interface includes a menu bar (File, Edit, Favorites, Avatar PM, Avatar CWS, Avatar M50) and a toolbar with various icons. The main content area displays the "Child / Adolescent Level of Care Utilization System" with a "Finalize" button. The section is titled "I. RISK OF HARM" and contains a detailed description of the risk dimension. Below the text is a rating scale with five options: 1-Low Risk, 2-Some Risk, 3-Significant Risk (selected), 4-Serious Risk, and 5-Extreme Risk. A lightbulb icon is present next to the "3-Significant Risk" option. The interface also includes an "Option" dropdown and a "Complete" button at the bottom.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 2

Score the client's functional status on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 3

Score the client's co-morbidity on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 4

Score the client's recovery environment on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 5

Score the client's resiliency and treatment history on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 6

On this page you indicate if the client is emancipated and you score the first Treatment, Acceptance Engagement field.



IMPORTANT

Go to page 7 to score the second Treatment, Acceptance Engagement field and then return to page 6 and click the Calculate Score button to generate a report that gives you the total CALOCUS score. Make a note of the score and enter it in the Total Score field.

AVPMCONV (LIVE) - BELLFLOWER, BERT (000930128)/CALOCUS

File Edit Favorites Avatar PM Avatar CWS Avatar MSO Help

Page 6 of 7

BELLFLOWER, BERT (000930128) Date Of Birth: 07/13/1965; Sex: Male

Child / Adolescent Level of Care Utilization System Finalize

VI. TREATMENT ACCEPTANCE AND ENGAGEMENT

The Acceptance and Engagement dimension measures both the child or adolescent's, as well as the parent and/or primary care taker's, acceptance of and engagement in treatment. For the purpose of this document, treatment includes an array of therapeutic interventions to address the child's, adolescent's, and parent and/or primary care taker's needs. The sub-scales reflect the importance of the parent and/or primary care taker's willingness and ability to participate pro-actively in the intake, planning, implementation, and maintenance phases of treatment. It also is critical to note that a parent or primary care taker's cultural background influences understanding and acceptance of a problem, as well as choice of care options for solving it. Care should be taken to note barriers to proper assessment and treatment based on cultural differences between the youth and parent and/or primary care taker and the clinician. If needed, consultation with or addition of culturally congruent staff may eliminate cultural barriers to effective assessment and treatment.

***Only the highest of the two sub-scale scores (child or adolescent vs. parent and/or primary care taker) is added into the composite score. In addition, if a child or adolescent is emancipated, the parent and/or primary care taker sub-scale is not scored.**

FOR DEMENSION RATING SCALE CLICK ON LIGHT BULB

Is Youth Emancipated?

Yes No

#8a - Treatment, Acceptance Engagement-Child/ Adolescent*

1-Optimal 2-Constructive 3-Obstructive 4-Adversarial 5-Inaccessible

Calculate Score Total Score 22

Option Complete

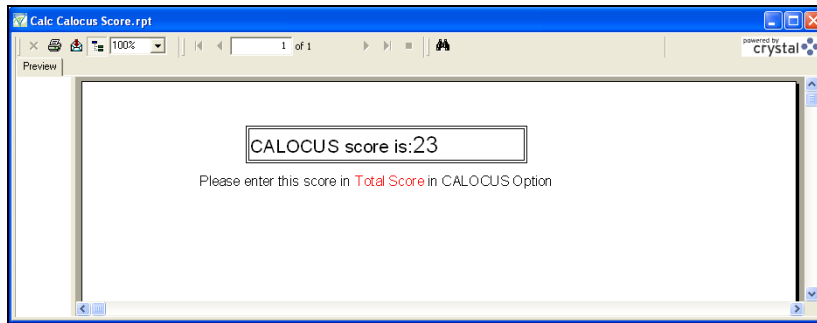
CALOCUS Chart Review

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 7

Score the second Treatment, Acceptance Engagement field on this page then return to page 6 to generate the report that calculates the score.

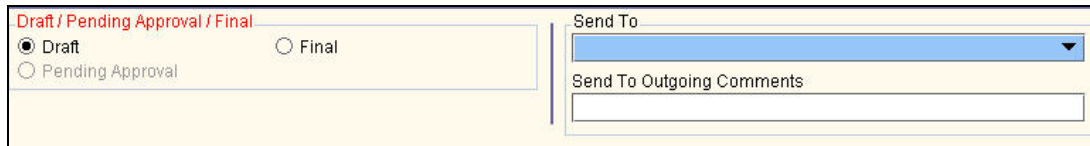
CALOCUS REPORT

The following illustration is an example of the Calc Calocus Score report.



FINALIZE TAB

Use this tab to submit the information as a Draft or Final. If you are an intern and need manager approval for this assessment, you have the option to select another staff member to send the assessment to for review and to provide outgoing comments.

A screenshot of a form section titled "Draft / Pending Approval / Final". On the left, there are three radio buttons: "Draft" (which is selected), "Pending Approval", and "Final". To the right of these buttons is a "Send To" dropdown menu with a blue arrow pointing down. Below the dropdown menu is a text input field labeled "Send To Outgoing Comments".



Exercise 7 Write a CALOCUS Assessment

In this exercise you will complete a CALOCUS assessment.

Before You Begin: Think of a fictitious client name you can use for this exercise. In this example Adam Apple is the client.

1. Choose Avatar CWS→Assessments→CALOCUS from the Menu Frame.
2. Choose 1-Low Risk in the Risk of Harm field.

FOR DIMENSION RATING SCALE CLICK ON THE LIGHT BULB

#1 - Risk of Harm

1-Low Risk 2-Some Risk 3-Significant Risk 4-Serious Risk 5-Extreme Risk

3. Click the Forward icon on the Option toolbar to move to page 2.
4. Select the 5-Severe rating for the Functional Impairment field.
5. Click the Forward icon on the Option toolbar to move to page 3.
6. Choose 3-Significant in the Co-morbidity field.
7. Click the Forward icon on the Option toolbar to move to page 4.
8. Select the 4-Highly rating for Environmental Stressors field and 2-Supportive for the Environmental Support field.
9. Click the Forward icon on the Option toolbar to move to page 5.
10. Choose 4-Poor in the Resiliency and Treatment History field.
11. Click the Forward icon on the Option toolbar to move to page 6.
12. Choose No for Is Youth Emancipated?
13. Choose 4-Adversarial in the #6a, Child/Adolescent field.
14. Click the Forward icon on the Option toolbar to move to page 7.
15. Choose 3-Obstructive in the #6b, Parent/Care-taker field.
16. Click the Back icon on the Option toolbar to return to page 6.

CALCULATE THE CALOCUS SCORE

Next you will generate a report that calculates the CALOCUS score and you'll enter the score in the CALOCUS window.

17. Click the Calculate Score button.

FOR DIMENSION RATING SCALE CLICK ON LIGHT BULB

Is Youth Emancipated?

Yes No

#6a - Treatment, Acceptance Engagement - Child/Adolescent*


1-Optimal 2-Constructive 3-Obstructive 4-Adversarial 5-Inaccessible

#6b - Treatment, Acceptance Engagement - Parent/Care-taker*

1-Optimal 2-Constructive 3-Obstructive 4-Adversarial 5-Inaccessible


Total Score

Avatar asks if you want to download the report.


18. Click OK to download the report.
19. Note the score that appears in the report window.
20. Click the Close  button to close the report window.
21. Enter the score in the Total Score field. (If you used the scoring indicated in the exercise, it should be 23.)

FOR DIMENSION RATING SCALE CLICK ON LIGHT BULB

Is Youth Emancipated? Yes No


#6a - Treatment, Acceptance Engagement -Child/ Adolescent* 

1-Optimal 2-Constructive 3-Obstructive 4-Adversarial 5-Inaccessible

#6b - Treatment, Acceptance Engagement -Parent/Care-taker* 

1-Optimal 2-Constructive 3-Obstructive 4-Adversarial 5-Inaccessible

Total Score

22. Click the Finalize tab.
23. Click the Final radio button.
24. When the message appears indicating that selecting Final prevents future edits, click OK.
25. Click the Submit  icon on the Option toolbar to save your work.



UNDERSTANDING THE MENTAL STATUS EXAM (ADULT + PIN) WINDOW

As the name indicates, you use this window as a piece of the Adult Assessment *or* PIN (for either Adult or Youth). For a youth mental status exam, use the Mental Status/Behavioral Observation (YOUTH) window.

NOTE: All behaviors and symptoms in this window are only rated if they are known to exist or were observed at the time of the interview. A non-response to any field indicates that the symptom or behavior was not known or observed.

There are 8 pages in the Mental Status and Behavioral Observation tab, broken down into Risk, Appearance/Speech, Motor Activity/Mood, Intellect/Affect, Behavior/Flow of Thought, Content of Thought/Hallucinations, and Delusions/Sensorium/Insight and Judgment. Only rate the fields in this tab that apply to your client. If an item does not apply, you may check the box next to Within Normal Limits.

WHO CAN PERFORM THIS FUNCTION?

A physician, licensed/waivered psychologist, licensed/registered clinical social worker, licensed/registered marriage and family therapist, or registered nurse with a master's degree in a mental health related field.

MENU PATH

Avatar CWS→Assessments→Mental Status Exam (Adult + PIN)

MENTAL STATUS EXAM TAB PAGE 1

Use this page to document the date and the type of assessment as well as any Current Concerns of Risk.

AVPMCONV (LIVE) - BELLFLOWER, BERT (000930128)/MENTAL STATUS EXAM (Adult + PIN)

File Edit Favorites Avatar PM Avatar CWS Avatar MSO Help

Page 1 of 8

BELLFLOWER, BERT (000930128) Date Of Birth: 07/13/1965; Sex: Male

Mental Status Exam Finalize

Assessment Date: 08/30/2010

Assessment Type: Adult Child/Youth

FOR ALL DOMAINS: Select items OBSERVED or KNOWN TO EXIST at time of the Assessment

Does a co-morbid condition impact this Mental Status Exam? Yes No Suspected Unknown

CURRENT Concerns of Risk

No Risk Concerns Suicidal Thoughts

Suicidal Plan Homicidal Thoughts

Homicidal Plan Assaultive Ideas

Self Harming Behavior Under Influence of Alcohol

Under Influence of Illicit Drugs Under Influence of Prescription Meds

Unable to Assess

Comments: CLIENT USING MOTHER'S PAXIL

MENTAL STATUS EXAM TAB PAGE 2

Use this page to document General Appearance and Speech.

MENTAL STATUS EXAM TAB PAGE 3

Use this page to document Motor Activity and Mood.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 4

Use this page to document Intellect and Affect.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 5

Use this page to document Behavior and Flow of Thought.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 6

Use this page to document Content of Thought and Hallucinations.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 7

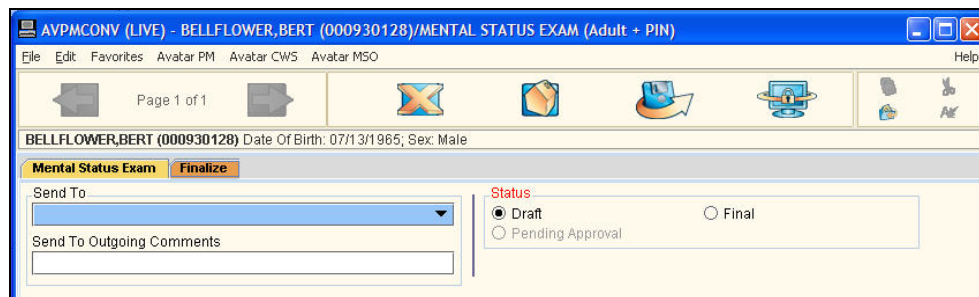
Use this page to document Delusions, Sensorium, and Insight and Judgment.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE

The Comments field for Insight and Judgment appears on this page.

FINALIZE TAB

Use this tab to submit the information as a Draft or Final. You have the option to select another staff member to send the Mental Status and Behavioral Observation assessment to for review and to provide outgoing comments.





Exercise 8 Write a Mental Status Exam

In this exercise you will complete a Mental Status Exam based on elements you observed directly while working with the client.

Before You Begin: Select the sample client you are working with. In this example the client is Adam Apple.



1. Choose Avatar CWS→Assessments→Mental Status Exam (Adult + PIN) from the Menu Frame.
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new Mental Status Exam.
3. Follow these steps to rate the client's risk characteristics:

A Select Adult for Assessment Type.


B Choose No for co-morbid impact and check Self Harming Behavior and Assaultive Ideas for Current Concerns of Risk.

C Type the comments shown here.


RATE GENERAL APPEARANCE AND SPEECH

4. Click the Forward  icon on the Option toolbar to go to page 2.
5. Choose Within Normal Limits for General Appearance and Soft and Slowed for Speech.
6. Click the Forward  icon on the Option toolbar to go to page 3.


RATE THE CLIENT'S MOTOR ACTIVITY AND MOOD

7. Choose Tremor for Motor Activity and Anxious and Irritable for Mood.
8. Click the Forward  icon on the Option toolbar to go to page 4.


RATE INTELLECT AND AFFECT

9. Choose Poor Abstraction and Poor Vocabulary for Intellect and choose Within Normal Limits for Affect.
10. Click the Forward  icon on the Option toolbar to go to page 5.

DOCUMENT BEHAVIOR AND FLOW OF THOUGHT

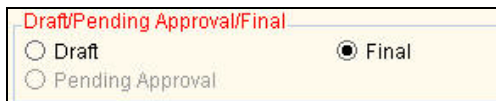
11. Choose Evasive for Behavior and choose Blocking and Incoherence for Flow of Thought.
12. Click the Forward  icon on the Option toolbar to go to page 6.

ENTER CONTENT OF THOUGHT AND HALLUCINATIONS DETAILS

13. Choose Within Normal Limits for Content of Thought and Auditory for Hallucinations.
14. Click the Forward  icon on the Option toolbar to go to page 7.

DOCUMENT DELUSIONS, SENSORIUM, AND INSIGHT AND JUDGMENT


15. Choose Mood Congruent for Delusions, Within Normal Limits for Sensorium, and Poor Judgment for Insight and Judgment.
16. Click the Finalize tab.
17. Click the Final radio button.



Draft/Pending Approval/Final

Draft Final

Pending Approval

18. When the message appears indicating that selecting Final prevents future edits, click OK.
19. Click the Submit  icon to save your work.



UNDERSTANDING MENTAL STATUS/BEHAVIORAL OBSERVATION (YOUTH)

NOTE: All behaviors and symptoms in this window are only rated if they are known to exist or were observed at the time of the interview. A non-response to any field indicates that the symptom or behavior was not known or observed.

There are 14 pages in the Mental Status and Behavioral Observation tab, broken down into Co-Morbid/Risk, Appearance, Motor Activity, Speech, Mood/Intellect, Affect, Behavior, Thought, Sensorium, and Insight and Judgment. On each of these pages, details only become available to fill out if you indicate there is a problem by selecting Yes at the beginning of each section. Only rate the fields in this tab that apply to your client. If an item does not apply, you may leave the field blank.



IMPORTANT

If you choose Yes to the Immediate Concerns of Risk Field, and you complete the page and then later decide to select No, Avatar will clear all selections in that section and you will need to re-enter them.

If you select an item by mistake, press the [F5] key to clear an option. Required fields cannot be cleared. If you select Yes for a required field by mistake, you cannot clear it. Select No instead.

WHO CAN PERFORM THIS FUNCTION?

A physician, licensed/waivered psychologist, licensed/registered clinical social worker, licensed/registered marriage and family therapist, or registered nurse with a master's degree in a mental health related field.

MENU PATH:

Avatar CWS→Assessments→Mental Status/Behavioral Observation (YOUTH)

DATE TAB

Use this tab to document the date and the type of assessment. Note the instructions for completing this document.

The screenshot shows the 'DATE' tab of the 'Mental Status and Behavioral Observation' form. The window title is 'AVPMCONV (LIVE) - APPLE, ADAM (000930026)/Mental Status/Behavioral Observation (YOUTH)'. The interface includes a menu bar (File, Edit, Favorites, Avatar PM, Avatar CWS, Help) and a toolbar with navigation icons. The main content area is titled 'APPLE, ADAM (000930021)' and contains the following fields and instructions:

- Date:** 01/27/2010
- Type of Assessment:** Radio buttons for 'Adult' and 'Child/Youth' (selected).
- Instructions:**
 - **** INSTRUCTIONS FOR COMPLETING THIS DOCUMENT ****
 - 1) THE FOLLOWING SYMPTOMS AND BEHAVIORS IN THIS DOCUMENT ARE ONLY RATED IF THEY WERE OBSERVED, OR KNOWN TO EXIST AT THE TIME OF OBSERVATION
 - 2) ALL REQUIRED (red) FIELDS MUST BE ANSWERED
 - 3) A "NON-RESPONSE" IN A FIELD INDICATES THAT THE SYMPTOM OR BEHAVIOR WAS NOT KNOWN OR OBSERVED
 - 4) PLEASE CONSIDER THE CULTURE AND AGE OF THE CLIENT FOR EACH SECTION

At the bottom, there is an 'Option' button and a 'Complete' button. The status bar shows 'Mental Status/Behavioral Observation (YOUTH)' and 'Chart Review'.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 1

Use this page to document whether a co-morbid condition impacts this assessment and any current concerns of client risk.

The screenshot shows 'PAGE 1' of the 'MENTAL STATUS AND BEHAVIORAL OBSERVATION' form. The window title is 'AVPMCONV (LIVE) - APPLE, ADAM (000930026)/Mental Status/Behavioral Observation (YOUTH)'. The interface includes a menu bar (File, Edit, Favorites, Avatar PM, Avatar CWS, Avatar MSO, Help) and a toolbar with navigation icons. The main content area is titled 'APPLE, ADAM (000930026)' and contains the following fields and instructions:

- Instructions:**
 - **** RATE ONLY THOSE ITEMS THAT APPLY ****
 - Press F5 to Clear a Selection
- Does a Co-Morbid Condition Impact This MSE?**
 - Radio buttons: Yes, No (selected), Suspected, Unknown
- Current Concerns of Risk?**
 - Radio buttons: Yes (selected), No
- Suicidal Thoughts:** Radio buttons: 1-Mild, 2-Moderate, 3-Severe
- Suicidal Plan:** Radio buttons: 1-Mild, 2-Moderate, 3-Severe
- Homicidal Thoughts:** Radio buttons: 1-Mild, 2-Moderate, 3-Severe
- Homicidal Plan:** Radio buttons: 1-Mild, 2-Moderate, 3-Severe
- Assaultive Ideas:** Radio buttons: 1-Mild, 2-Moderate, 3-Severe
- Self Harming Behavior:** Radio buttons: 1-Mild, 2-Moderate (selected), 3-Severe
- Under influence of Alcohol:** Radio buttons: 1-Mild, 2-Moderate (selected), 3-Severe
- Under influence of Illicit Drugs:** Radio buttons: 1-Mild, 2-Moderate, 3-Severe
- Under influence of Prescribed Medication:** Radio buttons: 1-Mild, 2-Moderate, 3-Severe

At the bottom, there is a 'Details' text box, an 'Option' button, and a 'Complete' button. The status bar shows 'Mental Status/Behavioral Observation (YOUTH)' and 'Chart Review'.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 2

This page focuses on the client's general appearance.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 3

This page focuses on the client's motor activity.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 4

This page focuses on the client's speech characteristics.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 5

This page focuses on the client's mood and intellect.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 6

This page focuses on the client's affect.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 7

This page focuses on the client's behavior.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 8

This page focuses on the client's flow of thought.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGES 9, 10, 11, 12

Pages 9-12 focus on the client's content of thought. Page 11 allows you to document hallucinations, and page 12 documents delusions. If you need to document any of the choices on these pages, you must select Yes to Content of Thought Within Normal Limits field on page 9. This will activate all fields on pages 9-12.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 13

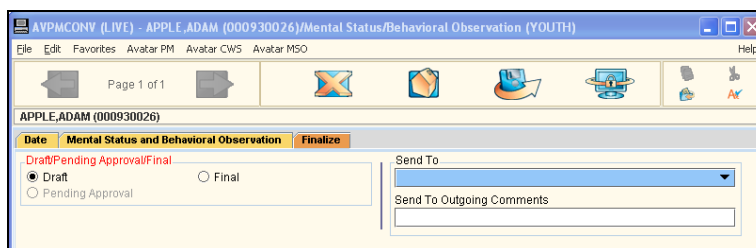
This page focuses on sensorium information.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 14

This page focuses on the client's insight and judgment.

FINALIZE TAB

Use this tab to submit the information as a Draft or Final. You have the option to select a staff member to send the assessment to for review and to provide outgoing comments.





Exercise 9

Write a Mental Status/Behavioral Observation (YOUTH) Assessment

In this exercise you will complete a Mental Status/Behavioral Observation based on elements you observed directly while working with the client.

Before You Begin: Select the sample client you are working with using the Select Client icon. In this example the client is Adam Apple.

1. Choose Avatar CWS→Assessments→Mental Status/Behavioral Observation (YOUTH) from the Menu Frame.
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new mental status assessment.

The Type of Assessment field defaults to Child/Youth and you cannot change it.



DOCUMENT RISK CONCERNS

3. Click the Mental Status and Behavioral Observation tab.
4. Follow these steps to rate the client's risk characteristics:


A Choose No for co-morbid impact and Yes for current risk concerns.

B Select Moderate for alcohol influence and Severe for prescribed medication influence.


RATE GENERAL APPEARANCE AND MOTOR ACTIVITY

5. Click the Forward  icon on the Option toolbar to go to page 2.
6. Choose Yes in General Appearance within Normal Limits.
7. Click the Forward  icon on the Option toolbar to go to page 3.
8. Choose Yes in Motor Activity within Normal Limits.



ENTER THE CLIENT'S SPEECH CHARACTERISTICS

9. Click the Forward  icon on the Option toolbar to go to page 4.
10. In SPEECH within Normal Limits, select No.
11. Only check the following items:
Slowed, select Moderate
Slurred, select Severe


RATE MOOD AND INTELLECT

12. Click the Forward  icon on the Option toolbar to go to page 5.
13. In MOOD (Self Report) within Normal Limits, select No.
14. Only check the following item: Depressed, select Moderate.
15. In INTELLECT within Normal Limits, select Yes.



DOCUMENT AFFECT AND BEHAVIOR

16. Click the Forward  icon on the Option toolbar to go to page 6.
17. In AFFECT within Normal Limits, select Yes.
18. Click the Forward  icon on the Option toolbar to go to page 7.
19. In BEHAVIOR within Normal Limits, select Yes.



ENTER FLOW OF THOUGHT DETAILS

20. Click the Forward  icon on the Option toolbar to go to page 8.
21. In FLOW OF THOUGHT within Normal Limits, select No.
22. Only check the following item: Incoherence, select Mild


RATE CONTENT OF THOUGHT

23. Click the Forward  icon on the Option toolbar to go to page 9.
24. In CONTENT OF THOUGHT within Normal Limits, select Yes.
25. Click the Forward  icon on the Option toolbar to go to page 10.


Because you selected Yes to normal Content of Thought on the previous page, the fields on this page are not active.

26. Click the Forward  icon on the Option toolbar to go to page 11.
Because you selected Yes to normal Content of Thought on the previous page, the fields on this page are not active.
27. Click the Forward  icon on the Option toolbar to go to page 12.
Because you selected Yes to normal Content of Thought on the previous page, the fields on this page are not active.

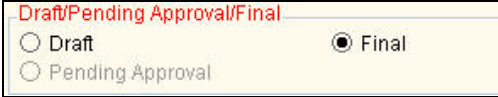

RATE SENSORIUM

28. Click the Forward  icon on the Option toolbar to go to page 13.
29. In SENSORIUM within Normal Limits field, select No.
30. Only check the following items:
Clouding of Consciousness, select Yes
Poor Recent Memory, select No

DOCUMENT INSIGHT AND JUDGMENT

31. Click the Forward  icon on the Option toolbar twice to go to page 14.
32. In INSIGHT AND JUDGMENT within Normal Limits, select Yes.

SUBMIT THE MENTAL STATUS AND BEHAVIORAL OBSERVATION

33. Click the Finalize tab.
34. Click the Final radio button.

35. When the message appears indicating that selecting Final prevents future edits, click OK.
36. Click the Submit  icon to save your work.



UNDERSTANDING THE SUBSTANCE USE ASSESSMENT WINDOW

Use this window to collect information about the client’s substance use, including an initial screening, drug history, and the client’s perceptions of drug use.



IMPORTANT

If you select None on page 1 of the Substance Use/Trauma tab for the Child/Youth Admission Assessment or None on the Co-Occurring Issues tab on the Adult Admission Assessment, the Substance Use Assessment is not required.

WHO CAN PERFORM THIS FUNCTION?

Only clinical staff can perform this function.

MENU PATH

Avatar CWS→Assessments→Substance Use Assessment

SUBSTANCE USE ASSESSMENT TAB PAGE 1

Document the date and type of assessment as well as the client’s perception of substance use and past attempts to stop.

NOTE: Document any substances that the client typically uses, not on this page, but on the Drug Use History tab.

Field	Description
A) Client’s Perception of Substance Use	If there is a previous Substance Use Assessment for this client, this field automatically populates from the previous assessment. Modify the information if appropriate.

SUBSTANCE USE ASSESSMENT TAB PAGE 2

Document how substance use affects mental health, the client's highest level of sobriety, current state of change, and family history of substance use.

DRUG USE HISTORY TAB

Document the client's drug use history on this page. For details on how to work with information in a multiple entry table, like the one on this page, see Lesson 6 in the *Introduction to Avatar* manual.

The screenshot displays the 'Drug Use History' tab within the 'Substance Use Assessment' software. The window title is 'AVPMTST (LIVE) - APPLE, ADAM (000930021)/Substance Use Assessment'. The interface includes a menu bar (File, Edit, Favorites, Avatar PM, Avatar CWS, Help) and a toolbar with navigation icons. The main content area shows a table with the following data:

Drug Name	Route of Administration	Current Usage Level, Amount, Frequency	Date of Last Use	Stage of Change
Marijuana	Smoked	3X / WEEK	2 DAYS AGO	1-Pre-Contemplation

Below the table are three buttons: 'Add New Item', 'Edit Selected Item', and 'Delete Selected Item'. The form below the table contains the following fields:

- Drug Name: Marijuana (dropdown)
- Other Drug: (text input)
- Route of Administration: Inhalation, Intranasal (Snorted), Intravenous (I.V.)
- Other Route: (text input)
- Age of 1st Use: 14
- Current Usage Level, Amount, Frequency: 3X / WEEK
- Highest Usage Level, Amount, Frequency: DAILY
- Date of Last Use: 2 DAYS AGO
- Stage of Change: 1-Pre-Contemplation (dropdown)

At the bottom, there are two tabs: 'Option' and 'Complete'. The 'Option' tab is currently selected. The bottom status bar shows 'Substance Use Assessment' and 'Chart Review'.

FINALIZE TAB

Use this tab to submit the information as a Draft or Final. If you are an intern and need manager approval for this assessment, you have the option to select a staff member to send the Substance Use Assessment to for review and to provide outgoing comments.



Exercise 10 Write a Substance Use Assessment

In this exercise you will complete a Substance Use assessment, including drug use history.

Before You Begin: Select a sample client you are working with using the Select Client icon. In this example Adam Apple is the client.

1. Choose Avatar CWS→Assessments→Substance Use Assessment from the Menu Frame.
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new Substance Use assessment.
3. Follow these steps to complete page 1 of the Substance Use Assessment tab:

A Choose Adult

B Choose No for urine specimen.

C Type the entry shown here.

D Type the entry shown here.

AVPMCONV (LIVE) - APPLE, ADAM (000930026)/Substance Use Assessment

File Edit Favorites Avatar PM Avatar CWS Help

Page 1 of 2

APPLE, ADAM (000930026)

Substance Use Assessment Drug Use History Finalize

Date Assessed: 02/24/2010 [T] [Y]

Assessment Type: Child/Youth Adult

Did Client Supply a Urine Specimen for Tox Screening? Yes No

Date of Tox Screen: []

Results of Tox Screen: []

Document substances client typically uses on DRUG USE HISTORY tab.

Client's Perception of Substance Use: Client does not see a problem.

Past Attempts to Stop Using and Outcomes: Nicotine patch 2007, Stopped ETOH 2001.

Option Complete

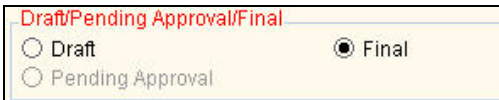

Substance Use Assessment Chart Review

4. Click the Forward icon on the Option toolbar to go to page 2.
5. In Does Substance Use Interfere/Exacerbate MH Problems field, type **Yes, heavy alcohol use increases suicidal thoughts.**
6. In Highest Level of Sobriety field, type **1 year clean 1999.**
7. In Client's Current Stage of Change field, type **Pre-contemplation.**
8. In Family History of Substance field, type **None.**

COMPLETE THE DRUG USE HISTORY

9. Click the Drug Use History tab.
10. Click the Add New item button to add a row to the table.
11. In the Drug Name field, select Amphetamines from the dropdown list.
12. In the Route of Administration field, select Oral.
13. In Age of First Use field, type **16**.
14. In Current Usage Level, type **2x/week**.
15. Click the Add New Item button to add another drug.
16. In Drug Name field, select Cocaine from the dropdown list.
17. In Route of Administration field, select Intranasal (Snorted).
18. In Age of First Use field, type **17**.
19. In Current Usage Level, type **None**.
20. In Highest Usage Level, type **Daily 1 Gram**.
21. In Date of Last Use field, type **November 2008**.
22. In State of Change field, select Maintenance from dropdown list.

FINALIZE THE ASSESSMENT

23. Click the Finalize tab.
24. Click the Final radio button.

25. When the message appears saying that Final prevents future edits, click OK.
26. Click the Submit  icon to save your work.



UNDERSTANDING BHRS DIAGNOSIS

This window collects DSM-IV diagnoses for Axis I and II (Diagnosis), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning). Provisional (rule out) diagnoses can also be documented and the primary diagnosis is identified here.

On any of the pages in the Diagnosis tab, you can click a blue underlined link to access the official DSM-IV website. Clicking these links opens a new window on top of Avatar.

If a Diagnosis was previously completed in Avatar, the last diagnoses on file for each axis will automatically appear in the field. Review the information from a previous diagnosis to determine if it is still accurate and edit the diagnosis accordingly.



IMPORTANT

When you see CSI next to a field, it indicates that it is State required information and the information will be visible in public reports.

WHO CAN PERFORM THIS FUNCTION?

Only clinical staff can perform this function.

MENU PATH

Avatar CWS→Assessments→BHRS Diagnosis

DIAGNOSIS TAB PAGE 1 (DIAGNOSIS INFO AND CSI)

All fields on this page are required. Document the diagnosis assessment, including Type of Diagnosis and Diagnosing Practitioner. The CSI fields at the bottom of the page are for California State required statistical purposes. If substance abuse is indicated, you must enter a substance abuse diagnosis. BHR5 diagnoses begin on page 2.

NOTE: If there is a previous diagnosis for this episode, the information autofills the current diagnosis. Modify this information as appropriate.

AVPMTEST (LIVE) - APPLE, ADAM (000930021)/BHR5 Diagnosis

File Edit Favorites Avatar PM Avatar CWS Help

Page 1 of 4

APPLE, ADAM (000930021) Episode: 2

Diagnosis Additional and Provisional Diagnosis Finalize

Diagnosis Info and CSI Axis I and II Axis III Axis IV and V

Date of Diagnosis: 01/27/2010 Time of Diagnosis: 11:40 AM Current H M AM/PM

Type of Diagnosis: Admission Discharge Update

Diagnosing Practitioner: BULL [Process Search]

Name/ID Number Unique Practitioner ID

BULL, INGALL (060050)

[DSM-IV-TR Online](#)

CSI Data Also Code Substance Abuse/Dependence Diagnosis in Axis I

Substance Abuse / Dependence (CSI): Yes No Unknown / Not Reported

Trauma (CSI): Yes No Unknown

Substance Abuse / Dependence Diagnosis (CSI): [Process Search]

30430 CANNABIS DEPENDENCE

Option Complete

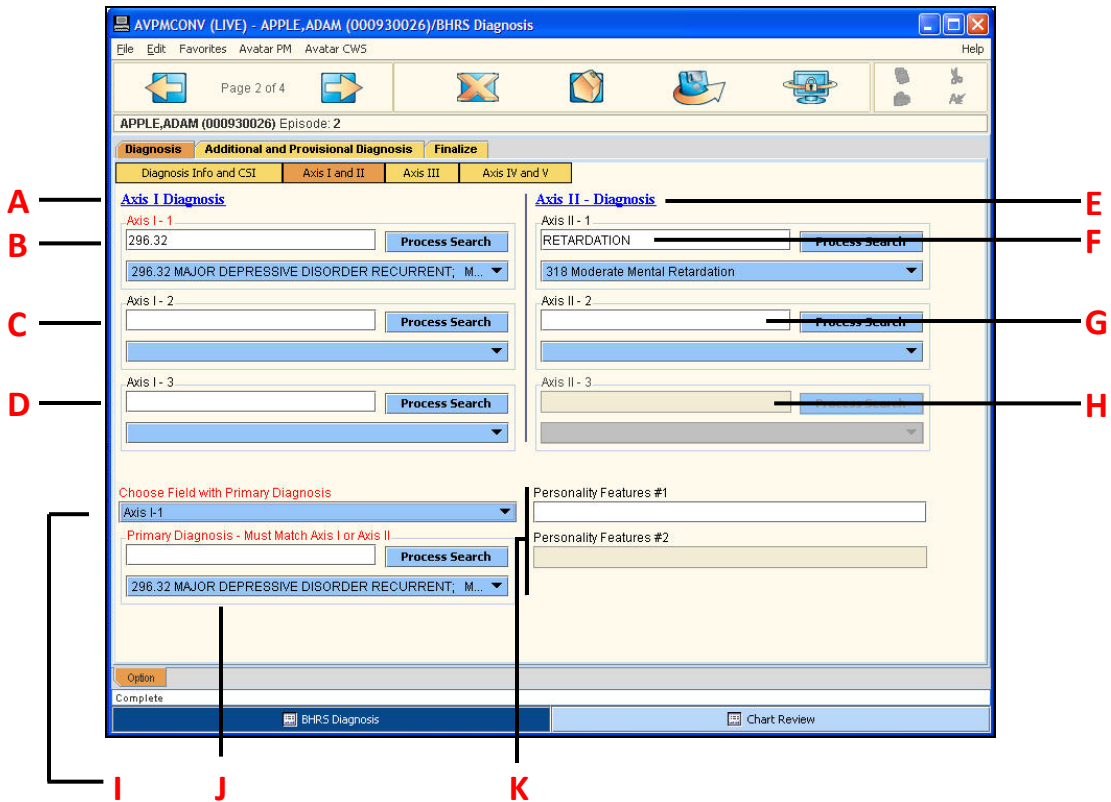
BHR5 Diagnosis Chart Review

DIAGNOSIS TAB PAGE 2 (AXIS I AND II)

Use this page to document the Axis I and Axis II diagnoses. If you do not know a code or official name for a specific diagnosis, you can use the blue Axis I Diagnosis and Axis II Diagnosis links at the top of the page to access the official DSM-IV website.

In the Axis fields, you can type all or part of the code number or description. In the example below, *296.32* was typed in the Axis I Diagnosis field to get the result Major Depressive Disorder Recurrent. In the Axis I-2 Diagnosis field, *Retardation* was typed to produce results in the dropdown menu with that keyword anywhere in the diagnosis. Click a choice in the menu to populate that diagnosis in the field.

Avatar will not allow you to make a diagnosis to the wrong Axis, for example, Major Depressive Disorder cannot be entered in an Axis II field.



Field/Link	Description
A) Axis I Diagnosis link	Click this link to access Axis I codes and definitions from the official DSM-IV website, which will open in a separate window on top of Avatar.
B) Axis I – 1	Type a DSM-IV code or part of the Axis 1 diagnosis name in this field and tap the [Enter] key.
C) Axis I – 2	Type a DSM-IV code or part of the secondary Axis 1 diagnosis name in this field and tap the [Enter] key.

Field/Link	Description
D) Axis I – 3	This field will only become active if diagnoses are entered in the Axis I – 1 and Axis I – 2 fields.
E) Axis II – Diagnosis link	Click this link to access Axis II codes and definitions from the official DSM-IV website, which will open in a separate window on top of Avatar.
F) Axis II – 1	Type a DSM-IV code or part of the Axis II diagnosis name in this field and tap the [Enter] key.
G) Axis II – 2	Type a DSM-IV code or part of the secondary Axis II diagnosis name in this field and tap the [Enter] key.
H) Axis II – 3	This field will only become active if diagnoses are entered in the Axis II – 1 and Axis II – 2 fields.
I) Choose Field with Primary Diagnosis	Select a diagnosis in the Axis I or Axis II fields as the primary diagnosis. The primary diagnosis must always match a Axis I or Axis II diagnosis.
J) Primary Diagnosis	This field auto-populates based on the choice you make in the Choose Field with Primary Diagnosis field.
K) Personality Features #1 and #2	These are personality traits. For example, if a client shows narcissistic traits that are not enough for a full diagnosis, you would type Narcissistic Features in this field.

DIAGNOSIS TAB PAGE 3 (AXIS III)

Axis III general medical condition information is required. You may check one or more checkboxes that apply. *No General Medical Condition* is an option in this list. If you select the checkbox next to Other, the Axis III-Other text field becomes required.



IMPORTANT

If you check Other from the Axis III list, you must click inside the Axis III-Other text field to activate it.

DIAGNOSIS TAB PAGE 4 (AXIS IV AND V)

For official descriptions and explanations of the Axis IV and Axis V questions on this page, use the blue Axis IV – Psychosocial and Environmental Problems and Axis V – Global Assessment of Functioning links at the beginning of each Axis section. These links open a web page with official DSM-IV information.

- Choosing Yes for an Axis IV entry indicates the *client does have a problem* in that area.
- In the Axis V GAF dropdown field, the first number in parenthesis, (31) for example, is the GAF score.

ADDITIONAL AND PROVISIONAL DIAGNOSIS TAB PAGE 1

You use this page to document additional Axis I, Axis II, and Axis III diagnoses. The Axis I and II fields on this tab are only available if you used all of the related fields on the Diagnosis tab.

You only need Axis-III here if you need to call out something that's not in the checkboxes on page 3 of the Diagnosis tab.

ADDITIONAL AND PROVISIONAL DIAGNOSIS TAB PAGE 2 (RULE OUT DIAGNOSES)

Use this page to document any Rule Out diagnoses for Axis I or II, if necessary.

FINALIZE TAB

Use this tab to submit the information as a Draft or Final. If you are an intern and need to get manager approval for this assessment, you have the option to select another staff member to send the assessment to for review and provide outgoing comments.




Exercise 11 Write a BHRS Diagnosis Assessment



In this exercise you will complete a diagnosis assessment.

Before You Begin: *Select a sample client to work with.. In this example Adam Apple is the client.*


1. Choose Avatar CWS→Assessments→BHRS Diagnosis from the Menu Frame.
2. If the Episode Selection screen appears, choose the episode that relates to this diagnosis.
3. If the Pre-Display screen appears, click the Add button to create a new Diagnosis.
4. In Type of Diagnosis, select Admission.
5. In Substance Abuse/Dependence field, select Yes.
6. In Trauma field, select No.
7. In Substance Abuse/Dependence Diagnosis field, type **CANNABIS** and tap the [Enter] key.
8. In the dropdown box, select 304.30 CANNABIS DEPENDENCE.

ENTER AXIS I AND AXIS II DIAGNOSES

9. Click the Forward  icon to go to page 2.
10. In Axis I-1 field, type **296.8** and tap the [Enter] key.
11. In the search result dropdown list, select 296.8 BIPOLAR DISORDER NOS.
12. In Axis I-2 field, type **BORDERLINE** and tap the [Enter] key.
13. In the search result dropdown list, select 301.83 BORDERLINE PERSONALITY DISORDER.

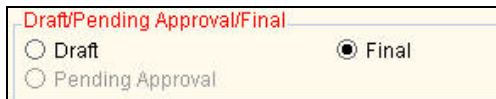
14. In the Choose Field with Primary Diagnosis field, select Axis I-1 from the dropdown list.
15. Click the Forward  icon to go to page 3.
16. In Axis III – General Medical Condition Summary Code field, check Arthritis and Asthma.
17. Click the Forward  icon to go to page 4.

ENTER AXIS IV AND V DIAGNOSES

18. In Axis IV – Primary Support Group field, select Yes.
19. In Axis IV – Social Environment field, select Yes.
20. In Axis IV – Housing, select Yes.
21. In Axis IV – Economic, select Yes.
22. In Axis IV – Legal system, select Yes.
You need a quick reminder of the Axis V GAF codes.
23. Click the blue Axis V – Global Assessment of Functioning link to open the official DSM-IV codes in a new Internet Explorer window.
24. Close the window when you are finished to return to Avatar.
25. In Axis V – Current GAF Rating field, select (41) 41-50 Serious Symptoms or Impairment.
26. Click the Additional and Provisional Diagnosis tab.
27. You do not need to document any additional diagnoses.
28. Click the Forward  icon to go to page 2.
You do not have any provisional (rule out) diagnoses.

SAVE THE ASSESSMENT AS A DRAFT

29. Click the Finalize tab.
30. Click the Final radio button.



Draft/Pending Approval/Final

Draft Final

Pending Approval

31. Click the Submit  icon to save your work.



CONCEPT REVIEW: ADMISSION ASSESSMENTS

See the appendix for answers.

1. How many different windows make up the complete admission assessment?
2. What happens to the Substance Use dropdown list in the Finalize tab if you select None on the Co-Occurring Issues tab?
3. If an assessment dropdown field is empty on the finalize tab, what is the problem?
4. True or False: You use the Medication History tab to prescribe medications for a client.
5. What do the lightbulb icons do?

APPENDIX—CONCEPT REVIEW ANSWERS

1. There are 5—Admission Assessment, LOCUS/CALOCUS, Substance Use, BHRS Diagnosis, Mental Status Exam (Adult + PIN) or Mental Status/Behavioral Observation (YOUTH).
2. The dropdown list becomes disabled.
3. That type of assessment has not been completed and finalized in the last 60 days
4. False. MDs use Infoscriber to prescribe medications. Clinicians and administrators can run the Infoscriber Medications report to see a current list of prescribed medications.