GLEN OAKS HOSPITAL

Patient Identification _____

Triage Form – Needs Assessment

Name: _____ Date of Birth: _____ Today's Date: _____

Name of Person Completing Form: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Who referred you to Glen Oaks today? _____ Contact Number: _____

Assessment Information:

Have you had any previous psychiatric hospitalizations? □Yes □No When? _____

Name of Hospital: _____ Reason for admission: _____

What level of service are you seeking today?

____Inpatient Treatment ____Intensive Outpatient ____Treatment Recommendations
____Partial (Day Treatment) ____Obtaining Psychiatrist/Psychologist ____Medication Management

Areas of Concern: (please explain)

_____ Appetite/Sleep Disturbance_____
_____ Marital or Relationship Stressor_____
_____ Problems at Work/School_____
_____ Feelings of Anger_____
_____ Excessive Worry or Unwanted Thoughts_____
_____ Having to do certain things over and over_____
_____ Difficulty Concentrating_____
_____ Depression/Sadness/Crying Spells _____
_____ Loss of Interest/Enjoyment in Sexual Activity_____
_____ Alcohol or Drug Use_____
_____ Easily Annoyed/Irritated/Tense/Nervous_____
_____ Temper Outbursts/Destructive to Property_____
_____ Impulsiveness/Acting Without Thinking_____
_____ History of Physical or Sexual Abuse_____
_____ Feelings that others are out to get you_____
_____ Seeing things that others do not see_____
_____ Hearing things that others do not hear_____
_____ Feelings of wanting to harm others_____
_____ Feelings of wanting to harm self_____
_____ List the date you last felt suicidal _____
_____ How strong is your desire to die right now? Strong _____ Moderate_____ Weak _____ None _____
_____ Do you have a plan as to how you would harm yourself? Yes _____No_____ Explain _____
_____ Have you ever attempted suicide in the past? _____ When? _____

What recent events/problems have brought about your request for help today? _____
_____