UC Basic Information

First Name:

Last Name:

AKA:
Status:
Date of Birth: **Gender:**
A No.: **LOS:**
Age: **Current Program:**
Child's Country of Birth: **Admitted Date:**

Initial Intakes Assessment

A staff member trained in use of this form completes it within 24 hours of the child's admission at the care provider facility. The staff member completing this form must be trained to ask and gather sensitive information in a child-friendly and culturally appropriate manner. The purpose of this interview is to learn about the child and demonstrate to him/her that caring for his/her safety and well-being is the care provider's foremost goal. In particular, these questions should help identify the severity of any medical or mental health needs the child has, ensure that the needs are appropriately met, facilitate gathering of basic identifying information, and inform the child's initial housing/bed assignment.

Child's Arrival Date/Time: **Intake Interview Date/Time:**
Child's Primary Language:
Intake conducted in what language:
Date of departure from home country: **Date of Arrival in the US (approx.):**

Family Information

Do you know anybody in the U.S.? Include relative and non-relative contacts in this section.

Name	Relationship	Address	Phone

Is there someone we can contact to let them know you are here?

Medical

Have you experienced any physical/medical problems today or in the last 30 days? ○ Yes ○ No
If yes, please explain:
Have you experienced any physical/medical problems? ○ Yes ○ No
If yes, please explain:
Do you have any allergies? ○ Yes ○ No
If yes, please explain:
Do you have any special dietary needs? ○ Yes ○ No
If yes, please explain:

Are you currently taking any prescribed or other medication? If yes, list below. Other medication may include herbal remedies, over-the-counter remedies etc.

○ Yes ○ No

Medication

Medication	Dose	Purpose

Observable or reported medical concerns (Check all that apply).

Concern	Yes/No

Coughing	Yes No
Difficulty Breathing	Yes No
Dehydration	Yes No
Dizzines	Yes No
Confusion	Yes No
Fever	Yes No
Pregnant	Yes No
Exhaustion	Yes No
Lice	Yes No
Injuries	Yes No
Bruises	Yes No
Burns	Yes No
Scabies	Yes No
Vomiting	Yes No
Abdominal Pain	Yes No
Coughing Blood	Yes No
Nausea	Yes No
Skin lesions/rash	Yes No
Sever/persistent headache	Yes No
Jaundice (Yellowing of the skin/whites of eyes)	Yes No
Neurological symptoms (Spasm, tics, uncontrollable movements, paralysis or numbness of any part of the body)	Yes No
Others(list)	Yes No

If injuries, wounds, bruises present, describe them and how they occurred:

List of other medical concerns:

Have you ever been to a doctor or stayed in a hospital? Yes No

If yes, please list any visit or stay for any reason. Also include visits to other healers or alternative treatment providers:

Do you have a history of tuberculosis? Yes No

If yes explain:

Do you have a history of seizures of convulsions? Yes No

If yes explain:

Do you have any scars, birthmarks, or tattoos? Yes No

If yes explain:

If any observed or reported medical concerns are checked in the sections above, please report these to Program Director, shift supervisor, and/or any on call medical staff immediately for further guidance on the need to seek immediate medical care.

Mental Health (Check all that apply)

Concern	Yes/NO
Tried to hurt yourself?	Yes No
Had urges to beat, injure or harm someone?	Yes No
Harmed anyone?	Yes No
Thought of attempting suicide or hurting yourself?	Yes No
Attempted suicide?	Yes No
Heard voices that others do not?	Yes No
Seen things or people that others do not see?	Yes No
Had trouble controlling anger or violent behavior?	Yes No
Are you having thoughts of harming yourself or someone else?	

Please explain any checked answers above:

Observable emotional concerns (Check all that apply)

Concern	Yes/NO
Cooperative	Yes No
Uncooperative	Yes No
Alert	Yes No
Distracted	Yes No
Calm	Yes No
Excited	Yes No
Nervous	Yes No
Agitated	Yes No
Confused	Yes No
Sad	Yes No
Angry	Yes No
Other	Yes No

If any the UC answered "yes" to any of the mental health questions and/or if any concerning behaviors and emotions were observed or reported, report to Program Director, shift supervisor, and/or any on call clinical staff immediately for further guidance on the need to seek mental health care.

Are you having thoughts of harming yourself or someone else?

Safety Assessment

Do you feel safe now? Yes No

Explain if No:

Do you fear that someone will harm you? Yes No

Explain if yes:

If the child answered "yes" to any of the safety health questions, report to Program Director or shift supervisor immediately for further guidance on how to ensure the child's safety.

Explain to the child where the child's room will be located in the facility, the number of potential roommates, the age and sex of the roommates, and the bathroom and shower area associated with the potential room assignment. After having explained this, does he or she identify any specific fears about this potential housing assignment? Yes No

Do you need anything right now?

Interviewer summary of critical issues that need immediate attention:

Action taken (each action should correspond to the concern described above):

Assessment For Risk

The Assessment for Risk must be completed by a Clinicianor qualified Case Manager within 72 hours of a child or youth's admission to the care provider facility.

Do you feel safe in your current room assignment or the assignment that will be given to you? Yes No

Explain:

Has anyone made any inappropriate comments to you about your body, clothes, or appearance that made you uncomfortable so far at this facility? Yes No

Explain:

Do you identify as:

If the child or youth identified as transgendered or intersex, then ask whether the child or youth would rather have a female or male staff member conduct a pat down search if one was necessary? Male Staff Female Staff

Do you feel safe telling people about your sexual preference during your time in ORR care? Yes No

Explain:

Is there something that you think we can do to help you feel safe and comfortable while you are here? Yes Not at this time

Explain:

Do you find that people make a lot of sexual comments to you or about you?* ○ Yes ○ No

Explain:

Have you ever been sexually active?

Have you ever felt like you needed to perform sexual favors or allow someone to touch your body in a sexual way in order to avoid additional harm, to obtain things you needed or wanted, or to be accepted by a person or group of people? ○ Yes ○ No

Explain:

Have you ever been in trouble for having sex with another person? ○ Yes ○ No

Explain:

Have you ever had to talk to a counselor, social worker, psychologist, teacher, or any other adult because of a sexual experience you had? ○ Yes ○ No

Explain:

QUESTIONS FOR CLINICIAN TO ANSWER: [Every Question Must Be Answered]

Does the child or youth exhibit any gender nonconforming appearance or manner? ○ Yes ○ No

Explain:

Does the child or youth have any current or criminal charges? ○ Yes ○ No

Explain:

Does the child or youth have any mental, physical, or developmental disability or illness or suspected of having any of the above?

What is the child's physical size and stature? ○ Average ○ Smaller than Average ○ Larger than Average

Other specific information that may indicate heightened needs and/or additional safety precautions: ○ Yes ○ No

Explain:

HOUSING, OTHER SERVICE ASSIGNMENTS, AND FOLLOW-UP

Housing and Other Service Plan

Clinician shared appropriate information with relevant care provider facility team ☐

Explain:

Child or youth provided with psycho education on identified issue ☐

Explain:

Child or youth provided with information on how to report threats, intimidation, or harassment by other children, youth, or facility staff ☐

Explain:

Child or youth moved to a private room ☐

Explain:

Child or youth moved to a room/dormitory area that matches the child or youth's gender identity (if different from sex) ☐

Explain:

Child or youth provided with alternative bathroom facilities or schedule ☐

Explain:

Child or youth placed in educational or activities group(s) to reflect child or youth's gender identity (if different from sex) ☐

Explain:

Developed and implemented a safety plan between child or youth, clinician, and care provider staff to address a specific issue ☐

Explain:

Implemented increased clinical sessions ☐

Explain:

Child or youth referred for professional mental health services ☐

Explain:

Child or youth placed on closer staff supervision ☐

Explain:

Staffed with FFS and CC for possible transfer ☐

Explain:

Other ☐

Explain:

Staff Signature: **Date:**

Staff Name: **Staff Title:**

Translator's Signature: **Date:**

Translator's Name: **Language:**