

**UC Basic Information**

**First Name:**

**Last Name:**

**AKA:**

**Status:**

**Date of Birth:**

**A No.:**

**Age:**

**Child's Country of Birth:**

**Gender:**

**LOS:**

**Current Program:**

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

Concern	Yes/No
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Coughing	<input type="radio"/> Yes <input type="radio"/> No
Difficulty Breathing	<input type="radio"/> Yes <input type="radio"/> No
Dehydration	<input type="radio"/> Yes <input type="radio"/> No
Dizziness	<input type="radio"/> Yes <input type="radio"/> No
Confusion	<input type="radio"/> Yes <input type="radio"/> No
Fever	<input type="radio"/> Yes <input type="radio"/> No
Pregnant	<input type="radio"/> Yes <input type="radio"/> No
Exhaustion	<input type="radio"/> Yes <input type="radio"/> No
Lice	<input type="radio"/> Yes <input type="radio"/> No
Injuries	<input type="radio"/> Yes <input type="radio"/> No
Bruises	<input type="radio"/> Yes <input type="radio"/> No
Burns	<input type="radio"/> Yes <input type="radio"/> No
Scabies	<input type="radio"/> Yes <input type="radio"/> No
Vomiting	<input type="radio"/> Yes <input type="radio"/> No
Abdominal Pain	<input type="radio"/> Yes <input type="radio"/> No
Coughing Blood	<input type="radio"/> Yes <input type="radio"/> No
Nausea	<input type="radio"/> Yes <input type="radio"/> No
Skin lesions/rash	<input type="radio"/> Yes <input type="radio"/> No
Sever/persistent headache	<input type="radio"/> Yes <input type="radio"/> No
Jaundice (Yellowing of the skin/whites of eyes)	<input type="radio"/> Yes <input type="radio"/> No
Neurological symptoms (Spasm, tics, uncontrollable movements, paralysis or numbness of any part of the body)	<input type="radio"/> Yes <input type="radio"/> No
Others(list)	<input type="radio"/> Yes <input type="radio"/> 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 or 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?	<input type="radio"/> Yes <input type="radio"/> No
Had urges to beat, injure or harm someone?	<input type="radio"/> Yes <input type="radio"/> No
Harmed anyone?	<input type="radio"/> Yes <input type="radio"/> No
Thought of attempting suicide or hurting yourself?	<input type="radio"/> Yes <input type="radio"/> No
Attempted suicide?	<input type="radio"/> Yes <input type="radio"/> No
Heard voices that others do not?	<input type="radio"/> Yes <input type="radio"/> No
Seen things or people that others do not see?	<input type="radio"/> Yes <input type="radio"/> No
Had trouble controlling anger or violent behavior?	<input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> Yes <input type="radio"/> No
Uncooperative	<input type="radio"/> Yes <input type="radio"/> No
Alert	<input type="radio"/> Yes <input type="radio"/> No
Distracted	<input type="radio"/> Yes <input type="radio"/> No
Calm	<input type="radio"/> Yes <input type="radio"/> No
Excited	<input type="radio"/> Yes <input type="radio"/> No
Nervous	<input type="radio"/> Yes <input type="radio"/> No
Agitated	<input type="radio"/> Yes <input type="radio"/> No
Confused	<input type="radio"/> Yes <input type="radio"/> No
Sad	<input type="radio"/> Yes <input type="radio"/> No
Angry	<input type="radio"/> Yes <input type="radio"/> No
Other	<input type="radio"/> Yes <input type="radio"/> 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 Clinician or 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:**