# ALTERNATIVE THERAPY, INC.

*A Professional Counseling Service*

**School-Referred In-Home Therapeutic Services Pilot Program**

## PRELIMINARY SAFETY & RISK SCREENING

**Purpose:** Brief pre-service screening of safety risks to the referred client, household members, and in-home clinicians. This form supports triage and home-visit planning and does not replace a comprehensive clinical or emergency risk assessment.

### 1. REFERRAL & CLIENT INFORMATION

**Client/Student Name:** _____

**DOB / Age / Grade:** _____

**School:** _____

**Parent/Guardian:** _____

**Home Address:** _____

**Referring Clinician/School Professional:** _____

**Title/Credentials:** _____

**Phone / Email:** _____

**Primary reason for referral / presenting concern:** _____

_____

_____

### 2. CLIENT SAFETY & BEHAVIORAL RISK

☐ No ☐ Yes ☐ Unknown Current/recent suicidal thoughts, statements, plan, intent, attempt, or self-harm

☐ No ☐ Yes ☐ Unknown Current/recent threats, aggression, violence, or intent to harm another person

☐ No ☐ Yes ☐ Unknown Running away, elopement, severe impulsivity, or dangerous/reckless behavior

☐ No ☐ Yes ☐ Unknown Severe agitation, loss of behavioral control, psychosis, or marked disorganization

☐ No ☐ Yes ☐ Unknown Current/recent substance intoxication, misuse, overdose, or withdrawal concern

☐ No ☐ Yes ☐ Unknown Suspected abuse, neglect, exploitation, domestic violence, or unsafe caregiving situation

☐ No ☐ Yes ☐ Unknown Recent psychiatric emergency evaluation, hospitalization, or acute crisis

**If YES to any item, briefly describe what occurred, when, current status, and actions already taken:**

_____

_____

_____

### 3. HOME / CLINICIAN SAFETY SCREEN

☐ No ☐ Yes ☐ Unknown Firearms, knives used as weapons, or other weapons are present or accessible in the home

☐ No ☐ Yes ☐ Unknown Household member has threatened, assaulted, intimidated, or behaved aggressively toward others

☐ No ☐ Yes ☐ Unknown Aggressive, territorial, or poorly controlled dog or other pet/animal is present

☐ No ☐ Yes ☐ Unknown Active substance use, intoxication, drug activity, or unsafe individuals may be present during visits

☐ No ☐ Yes ☐ Unknown Known domestic violence, serious family conflict, or volatile household interactions

☐ No ☐ Yes ☐ Unknown Unsafe physical/environmental conditions (e.g., infestation, structural hazard, blocked exits)

☐ No ☐ Yes ☐ Unknown Clinician may be unable to safely enter, exit, park, or conduct a private therapeutic visit

☐ No ☐ Yes ☐ Unknown Any other known concern that could place the client, family, or visiting clinician at risk

**Weapons/pets/environmental details and safety precautions needed before a home visit:**

_____

_____

_____

### 4. PRELIMINARY SERVICE / SAFETY DETERMINATION

**Based on information currently available, the referral is:**

☐ Appropriate to proceed with routine intake / home-visit planning

☐ Appropriate only with additional safety planning or clinician consultation

☐ Requires further risk assessment/information before any home visit

☐ Not appropriate for an in-home visit at this time; alternate/higher level of care or emergency response should be considered

**Required precautions / follow-up:**

_____

## 5. REFERRING CLINICIAN / SCHOOL PROFESSIONAL ATTESTATION

I certify that, to the best of my knowledge, the information above is accurate and that I have disclosed known safety concerns reasonably relevant to an in-home visit. I understand that urgent or imminent safety concerns require immediate crisis/emergency action and should not be managed solely through this referral process.

**Printed Name / Credentials:** _____

**Signature:** _____

**Date / Time:** _____

## 6. ALTERNATIVE THERAPY, INC. REVIEW

**Reviewed By / Credentials:** _____

**Date / Time:** _____

☐ Accepted for intake ☐ Safety consultation required ☐ More information required ☐ In-home visit deferred/not appropriate

**Comments / safety plan:** _____

_____

_____