Mississippi Division of Youth Services

Medical Services

Initial Admission Screening Tool

To be completed by Registered Nurse

This form shall be utilized at the youth's initial arrival at OYDC. It provides information that will determine whether OYDC will authorize admission.

Youth Name	DOB	Sex	Date/Time

Temp:________ O2 Sat:______ Pulse:_______ Respirations:______ BP: ______/______

OBSERVATIONS

	No	Yes	Describe
1. Is the Youth Unconscious?	☐	☐	__________________
2. Does the Youth have obvious injury (ies)	☐	☐	__________________
3. Does the Youth appear to be under the influence of alcohol and or drugs?	☐	☐	__________________
4. Does the Youth exhibit visible signs of alcohol and/or drug withdrawal? e.g. profuse sweating, vomiting, shakes, doubled over with cramps?	☐	☐	__________________
5. Does the Youth exhibit Bizarre or unusual behavior? e.g. .confused, incoherent or violent	☐	☐	__________________

Questions

	No	Yes	Describe
1. Are you thinking of hurting &/or killing yourself now?	☐	☐	__________________
2. Are you thinking of hurting &/or killing anyone now?	☐	☐	__________________
3. Are you bleeding?	☐	☐	__________________
4. Do you have a serious injury?	☐	☐	__________________
5. Do you currently have a communicable disease? e.g. Mumps, Chicken Pox, TB	☐	☐	__________________
6. Do you have a serious Dental problem?	☐	☐	__________________
7. Do you, an arresting and/or transporting officer Have information that indicates the youth is a Medical, mental health or suicide risk now?	☐	☐	__________________

Intake Referral

________ OK for admission

________ Needs Immediate referral for potential Psychological problem

________ Referred to Facility Administrator, for admission decision

Signed: ______________________________ Date: ____________________Time:__________