

Which Caregiver/Adult Was Involved (Client Name)?

Date of Activity: ____ / ____ / ____

Program

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance (PMI)
- Teen Pregnancy (TPTCM)
- Kansas Connecting Communities

GAD – 7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Totals				

Total (all boxes) = _____

GAD – 7 score of 0, 1, 2, 3, or 4 indicates patient is at a low risk of experiencing anxiety. Provide positive reinforcement and follow up at next appointment.

GAD – 7 score of 5, 6, 7, 8, or 9 indicates patient could be experiencing mild symptoms of anxiety. Provide brief intervention (support, resources, available treatment options). Complete the plan of action form on the next page.

GAD – 7 score of 10, 11, 12, 13, or 14 indicates patient could be experiencing moderate symptoms of anxiety. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.

GAD – 7 score of 15, 16, 17, 18, 19, 20 or 21 indicates patient could be experiencing severe symptoms of anxiety. Provide brief intervention and referral for further assessment and/or treatment. Complete the plan of action form on the next page.

Programs Providing Follow-Up: (select all that apply)

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance Initiative (PMI)
Teen Pregnancy Targeted Case
Management(TPTCM)
- Kansas Connecting Communities (KCC)

Was a brief intervention provided?

- Yes
- No

If yes, what brief intervention was provided?

- Reviewed screening results
- Made clinical recommendations
- Provided education community, and/or
treatment resources
- Measured patient-motivation and/or readiness
to change
- Reinforced self-efficacy
- Other **Specify other intervention:**

Why was a brief intervention not provided?

Was a referral provided?

- Yes
- No

What provider type was client referred to?

- Beacon Health Options
- Substance Use Treatment Provider
- Internal Mental Health Provider
- External Mental Health Provider CMHC
- External Mental Health Provider Private Practice
- MCO/MCO Care Coordinator
- Community-Based Support Group
- Primary Care Provider
- Other

If other, please specify: _____

Why was a referral not provided?

Was the client in crisis?

- Yes
- No

If yes, what action was taken?