**Behavioral Health Administration (BHA)**

**Hospital Sexual Abuse Risk Screen – Adults**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate why this form is being completed:

\_\_\_\_ Initial (within 48 hours after admission)

\_\_\_\_Treatment Plan update \_\_\_\_\_\_\_\_\_\_\_\_ [date]

\_\_\_\_Receipt of abuse allegations

\_\_\_\_ Receipt of other relevant information

**Instructions:**

This form has three purposes:

(a) to assist in developing a Protection Plan for the individual, if needed;

(b) to consider when planning treatment; and

(c) to consider when planning training for the individual.

A. Individual as Potential Victim

| # | Factor | Source | Identify/Describe, None, OR Unknown |
| --- | --- | --- | --- |
| 1 | Existing intellectual disability diagnosis? |  |  |
| 2 | Apparent Physical disability |  |  |
| 3 | Cognitive Limitations |  |  |
|  | -- orientation |  |  |
|  | -- memory |  |  |
|  | -- confusion |  | Presence? Absence? |
| 4 | Sexual disinhibitions |  |  |
| 5 | Poor physical boundaries |  |  |
| 6 | Childhood physical abuse |  | by:  Frequency:  # of years: |
| 7 | Childhood sexual abuse |  | by:  Frequency:  # of years: |
| 8 | Childhood witness to family violence |  | Type:  By:  Frequency:  # of years: |
| 9 | History of being in foster care |  | When?  How many homes?  Any trauma? |
| 10 | History of domestic or partner violence |  |  |
| 11 | Significant events |  | 1st institutionalization:  # of years of incarceration:  Number of incarcerations |
| 12. | History of being a victim of violent criminal acts |  | Crime/act:  Date:  Prison dates: |
| 13 | History of being a victim of sexual abuse as adult |  | Type of assault  Where (institution or community)  Date of most recent:  Judicial action taken: |
| 14 | History of being a victim of physical assault as adult |  | Type of assault  Where? (institution or community):  Date of most recent:  Judicial action taken: |
| 15 | Fear of being sexually abused or assaulted |  | Where?  Recent increase/decrease in fear?  Any patient suggestions to alleviate? |
| 16 | Evidence of PTSD that is relevant to risk of sexual abuse in the facility |  | Explanation:  Is further assessment needed? Y ? N |

B. Individual as Potential Risk to Others

| # | √ | Factor | Source | Identify/describe, None, OR Unknown |
| --- | --- | --- | --- | --- |
| 1 |  | Relevant impulse control issues |  | Current?  Primary behaviors: |
| 2 |  | Anger management issues |  | Current?  Primary behaviors: |
| 3 |  | History of being abused sexually as child or adult |  | Type of assault  By  Frequency  Institution or community  Date of most recent:  Judicial action taken: |
| 4 |  | History of being abused physically as child or adult |  | Type of assault  By  Frequency  Institution or community  Date of most recent:  Judicial action taken: |
| 5 |  | History of sexual offenses |  | Offenses:  Dates:  Incarceration? |
| 6 |  | History of threatening violence |  | To whom?  Where? |
| 7 |  | History of violent behavior: circle those that apply, and/or add others |  | toward a person  Toward property  With substance abuse |

Prepared by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature [Licensed Clinical Staff]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date

Conclusion: Safety & Risk of Harm **is / is not** a Treatment Plan Problem [circle one].

**If it is a Treatment Plan Problem, prepare a Protection Plan for the individual.**

Describe risk, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reasons for Conclusion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, Position [Treatment Team Head] Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

Provide Treatment Plan Problem Number: \_\_\_\_\_\_

For Official Use