**{INSERT NAME OF YOUR CLINIC}**

**EBP PRE-GROUP SCREENING** **FORM**

**EBP Group**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Facilitator(s)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient** | **Rank** | **DOB**  | **Gender** | **Contact Information** |
|  |  |  |  |  |

**Referral Source:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Reason for Wanting to Join Group:**

What are you hoping to learn from participating in the group?

How motivated are you to get help for this condition on a scale of 0-10, where 0 is not at all motivated and a 10 is completely motivated?

How motivated are you to attend group therapy on a scale of 0-10, where 0 is not at all motivated and a 10 is completely motivated??

Do you have any worries or fears about starting the group?

**Past History of Therapy:**

Have you ever tried this therapy before? Y / N

 If yes, in group or individual therapy? Group / Individual

Have you ever stopped a treatment before it concluded or before the goals were met? Y / N

 If yes, what led to that? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confirm Understanding of Group Logistics:**

Are you able to attend at the set date and time? Y / N

 If no, what is your preferred day and time? M / T / W / R / F AM / PM

Review group format (content/focus on diagnosis, treatment goals, structure, time, attendance requirement, number of sessions, ground rules, not a process group, homework, etc.). Do you agree? Y / N

**Outcome Measures (Baseline)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| **Measure** | **Date**  | **Score** | **Interpretation** |
|  |  |  |  |
|  |  |  |  |
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**Clinic-Specific Inclusion Criteria Reference Table {{adjust as needed}}**

|  |  |  |
| --- | --- | --- |
| **Name of Group** | **Diagnoses or Issues that are Appropriate (circle)** | **Cut-off Scores (if used)** |
| Cognitive Processing Therapy (CPT) | PTSD. Plus co-morbidities: Depression, substance misuse, Dissociative D/O (if controlled), bereavement, childhood abuse, adjustment D/O, mTBI | PCL-5: >\_\_\_\_  |
| Depression Management Group | Any unipolar depressive disorder: (major, persistent, unspecified, single/recurrent episode, etc.)including Adjustment D/O with depressed mood | PHQ-9: >\_\_\_\_ |
| Anxiety Group (Transdiagnostic) | Generalized Anxiety D/O, Panic D/O, Specific Phobia, Social Phobia, Obsessive-Compulsive D/O, PTSD | GAD-7 >\_\_\_\_ |
| CBT-Insomnia Group | Insomnia | ISI >\_\_\_\_ |
| Stress Management Group | Patient report of stress at home, work, or relationships  | N/A |
| **Possible inclusion factors:** | Issues compatible with goals of group, motivation to change, ability to participate appropriately: share information, communicate sufficiently, complete assignments and outcome measures, etc. |
| **Possible exclusion factors:** | Acute crisis, chronic psychosis, insufficient impulse control, marked anti-social traits, victim/perpetrator/other severe incompatibility with current member, gender or trauma type (if specified), leaving/will not be able to complete group, asymptomatic, etc. |

**Summarize Screening of Current Suitability for Group:**

Inclusion factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exclusion factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problem with alcohol/drug use: Y / N Treatment for alcohol/drug use: Past / Present

Current prescription medications for symptoms related to sleep or anxiety: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Circle: Yes No** (Reason): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Screening performed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not appropriate for group, describe recommendation(s) made to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not appropriate for group, describe action taken by staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Action performed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_