EASA Brief Screening Tool

This tool is meant to be a brief, 10–15-minute eligibility screening that can be completed over the phone with the referent or referred participant/family. The information gathered in this tool can assist with identifying automatic rule-outs or areas for further exploration and does not take the place of a full eligibility assessment.

Participant Information	
Participant name, pronouns, and ID	
Contact information	
Family/support(s) name(s) and contact (if applicable)	
Communication/accessibility needs (interpreter and/or translation services, written communication, etc.)	
Referent name, agency (if applicable), and contact information	

Demographics: age, race, ethnicity, cultural/spiritual/identity factors, living situation, educational and vocational status (work, school), languages spoken

Presenting Problem: active reason for seeking help, behavior changes, noted symptoms, onset of changes		
Symptom	**Description**	**Estimate of Onset**
Anxiety		
Depression		
Mania		
Hallucinations		

Delusions		
Disorganized speech or difficulty communicating		
Behavioral and/or functional changes across domains (work, school, family/home, self-care, hobbies)		
Suicidal/homicidal ideation		
Other (risk factors, Clinical high-risk symptoms, etc.)		

Current Treatment/Treatment History (including estimated dates of treatment, current or previous diagnoses, medications, etc.)	
Mental health diagnosis/treatment	
Medications (current and past, reactions to medication)	
Hospitalizations	

Substance Use/Misuse (level of use, recent or ongoing SUD use/misuse/treatment)	
Substance	**Frequency, amount, current use/last time used/treatment**
Cannabis (type and method of use)	
Alcohol	
Hallucinogens (mushrooms, LSD, etc.)	
Stimulants (methamphetamines, cocaine, MDMA, bath salts, etc.)	
Opioids (oxycodone, fentanyl, hydrocodone, heroin, etc.)	
Other: Kratom, etc.	

Developmental/Medical History	
Condition	**Onset/age of diagnosis, severity, effects on functioning**
Family history of psychosis/schizophrenia spectrum disorders	
Autism Spectrum Disorder	
Intellectual/Developmental Disability	
Head trauma	
Seizures	
Other physical health problems	

Outcome of Brief Screening		
☐ Schedule for further assessment/full screening	Date of scheduled follow up assessment	
☐ Refer to other services	Date that outcome was discussed with family/participant/referent	
	Service/program referred to and date referral completed	
	Date that letter with screening outcome and resources was emailed and/or mailed	