

TeleMental Health Assessment for Client Fit

** There must be a check next to each question for the client to be appropriate for TeleMental Health treatment.

Client Safety:

Please Check

- | | |
|---|---------------|
| 1. Is the client suicidal or homicidal or at high risk of harming self or others? | No: |
| 2. Is the client psychotic or paranoid (worried that authorities will be listening or electronic devices may harm him/her in some way)? | No: |
| 3. Is the client willing to let the therapist know his/her location (address) each session? | Yes: |
| 4. Is the client willing to give the therapist a name and phone number of a person to call in case of an emergency? | Yes: |
| 5. Does the client have a place to conduct a TeleMental Health session that is confidential? | Yes: |
| 6. Is the client in a domestic violence or abusive situation where his/her abuser could find out that TeleMental sessions were occurring and result in more violence? | Yes: No: |
| a. If email or texting is part of the treatment, does abuser have access to these accounts? | No: N/A: |
| b. If the telephone is involved, does the abuser have access to the history on client's phone or information on phone bill? | No: N/A: |
| c. If chat rooms, client portals, websites, apps, etc. are going to be used, does the abuser have access to the electronic device the client will use and associated history of where client has been online? | No: N/A: |

Client's Presenting Concern & Appropriateness:

- | | |
|---|------|
| 1. Is the client avoiding something by not coming to sessions in person (e.g., not facing a driving phobia, is socially anxious, has attachment issues, has an alcohol use disorder and doesn't want the therapist to smell his/her breath, etc.) | No: |
| 2. In general, is TeleMental Health therapy a solid option for this client's presenting concern and the therapist can document the rationale? | Yes: |
| 3. Is there any language barrier/cultural issue/medical or physical issue that may cause difficulty in utilizing TeleMental health interventions? | No: |

Client's Technological Ability:

- | | |
|--|------|
| 1. Is the client willing to have the initial session in person or via video-conferencing in order to see client and check identification? | Yes: |
| 2. Does the client have the technology needed to engage in the type of TeleMental Health you are offering (computer, internet, smart phone, appropriate software, etc.)? | Yes: |
| 3. Is the client willing to use the appropriate software to maintain confidentiality? | Yes: |
| 4. Does the client have the skill to use the means of receiving TeleMental Health services as proven by testing the technology with you or a friend prior to your session? | Yes: |
| 5. Is the client willing to use a code word or phrase each session to ascertain identity? | Yes: |
| 6. Has the client been informed of the procedures in case of a technological interruption of services, the client is comfortable with the protocol, and the possible interruption of services is not too stressful for client? | Yes: |

General Information:

- | | |
|---|------|
| 1. Has the client been informed as to whether insurance will cover TeleMental Health sessions or not? | Yes: |
| 2. Will the client be in a state where you are licensed or have temporary authority to practice? | Yes: |

TeleMental Health Assessment for Client Fit

Client Assessment:

Please Check

1. I find this client to be appropriate for the TeleMental Health Video Therapy Program.

Yes: No:

Client Name

Client Date of Birth

Additional Comments:

My electronic signature below verifies that I have assessed my client for their fit with the TeleMental Health Program and the answers above represent my accurate understanding of their current situation and appropriateness for using Video-based Therapy.

Signature

Date