PSYCHIATRIC EVALUATION REFERRAL

Case Name:

Evaluating Physician's Name:

Evaluation Address:

Number and Street:

County:

City: State: Florida Zip:

Telephone (area code and number): (ext.:)

Date/Time of Scheduled Evaluation:

Case Manager Instructions: This Referral must be completed for all psychiatric evaluation requests. This referral must be provided to the physician prior to the child's evaluation (unless the child is hospitalized of in SIPP, in which case the Referral may be filled out after the child receives medication based on information received from hospital/SIPP. This form must also be provided to the CLS attorney, parents, guardian *ad litem* if one has been appointed.

If medications are prescribed, upon doctor's completion of the Medical Treatment Plan, this Referral must be attached to the Medical Treatment Plan and both faxed to the CLS. IF there are any problems with the request of medication, CLS will notify the case manager and the CBC in order to quickly remedy the problems. CLS may also attempt to contact the physician directly.

I. CHILD'S INFORMATION

Child's Name:	DOB:	
Child's Height:	Child's Weight:	Gender:
FSFN Case No.:	Assigned Attorney:	Judge:

II. CONTACT INFORMATION

Case Manager:	Phone:	Email:
Case Manager Supervisor:	Phone:	Email:
Contracted Agency:	Phone:	Email:
Caregiver: (if not confidential)	Phone:	Email:
Therapist name:	Phone:	Email:
Primary care phys. Name:	Phone:	Email:
Treating psy-chiatrist name:	Phone:	Email:
GAL name: (if assigned)	Phone:	Email:
School name:	Phone:	Email:
Mother: (if not terminated)	Phone:	Email:

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Father:
(if not terminated)

Phone:

Email:

III. AVAILABLE DOCUMENTS, PRIOR REPORTS. Please list all known prior evaluations or reports on the child. Include dates. Ex: psychiatric, psychological, mental health assessment, CPT, forensic interviews, etc. Please ATTACH any evaluation that specifically requested this evaluation.

IV. CHILD HISTORY, BACKGROUND

Please check all that apply to this child.

- ☐ history of substance abuse
- ☐ history of non-compliance with medications
- ☐ history of psychiatric hospitalization/residential treatment center
- ☐ currently placed in psychiatric hospital/residential treatment center
- ☐ history of violence or threats of violence (to self or others)
- ☐ depression
- ☐ social or developmental delays
- ☐ other:
- ☐ specific suicidal statements or actions
- ☐ traumatic experiences
- ☐ prior psychiatric diagnoses
- ☐ current non-psychiatric medical condition
- ☐ recent change in mood or behavior
- ☐ family mental health history
- ☐ family history of substance abuse
- ☐ family history of domestic violence
- ☐ academic or social difficulties

Symptoms began with last (number) ☐ days, ☐ weeks, ☐ months, ☐ years; or ☐ lifelong.

Who has reported the symptoms? ☐ the child, ☐ placement, ☐ school, ☐ physician, ☐ parent, ☐ case manager, ☐ other (please list):

History of Abuse: ☐ abandonment, ☐ neglect, ☐ physical, ☐ sexual, ☐ emotional

V. SYMPTOMS NARRATIVE

Please describe any behaviors and symptoms of the child that have led to the request for this evaluation. In addition, include explanation of any factors checked in Section IV.

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VI. PSYCHOTROPIC MEDICATION AND SERVICES HISTORY

List below or attach a list of all known medications that child has taken or *is taking* at the time this referral is being made. Also list below or attached all psycho-social services (including therapy, CBAs, and any school services) the child has received. Repeat page as necessary.

Medication Name	Dosage	Start Date	End Date	Prescribing Physician and Contact number	Reason for Medication

Service/Therapy	Start Date	End Date	Frequency	Provider's Name and Phone Number (if Known)