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 in an 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, and 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 Physician name:	Phone:	Email:
Treating Psychiatrist name:	Phone:	Email:
GAL name: (if assigned)	Phone:	Email:
School name:	Phone:	Email:
Mother: (if not terminated)	Phone:	Email:

Comment [AB1]: Case Name from Forms window

Comment [AB2]: User Enterable

Comment [AB3]: User Entered

Comment [AB4]: The Evaluation Address section is user entered

Comment [AB5]: User Enterable

Comment [AB6]: This section pre-fills the information for the child id passed from the Create Case work window

Comment [AB7]: Pre-fills with Child Name from Person management

Comment [AB8]: Pre-fills with Child DOB from Person management

Comment [AB9]: User Entered

Comment [AB11]: Pre-fills with Child Gender from Person management

Comment [AB10]: User Entered

Comment [AB12]: Pre-fills with FSFN Case No

Comment [AB13]: Pre-fills with the most recent Legal Page's Legal Actions and Status Tab's CLS Attorney value

Comment [AB14]: Pre-fills with the most recent Legal Page's Legal Actions and Status Tab's Judge value

Comment [AB15]: Pre-fills with Primary Assigned worker's Name, Phone and Email from Worker Management window

Comment [AB16]: Pre-fills with Primary Assigned worker's supervisor's Name, Phone and Email from Worker Management window

Comment [AB17]: Pre-fills from Primary Assigned worker's unit to derive the Contracted Agency from the Maintain Agency Window's Association Tab

Comment [AB18]: Pre-fills with the Primary Giver Name, Phone and Email Address from ...

Comment [AB19]: Pre-fills with the MH Professional Name and Phone from the ...

Comment [AB20]: Pre-fills with the Physician/Clinic Name and Phone from the ...

Comment [AB21]: Pre-fills with the Psychiatrist Name and Phone from the ...

Comment [AB22]: Guardian Ad Litem (GAL) from Maintain Case - Repeating Table.

Comment [AB23]: Pre-fills with the School Name and Contact Phone from the Education ...

Comment [AB24]: Repeated Table pre-fills with the Mother Name from Person ...

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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.

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.

Comment [AB25]: Repeated Table pre-fills with the Father Name from Person Management Basic tab and Phone and Email from most recent primary address on the Person Management's Address Tab for Case Participant's relationship defined as Father on the Maintain Case Relationship Tab

Comment [AB26]: All the fields in this section are user enterable

Comment [AB27]: User Entered

Comment [AB28]: All the fields in this section are user enterable

Comment [AB29]: Pre-fills from Medical/Mental window's Mental health profile's Substance Use groupbox. If any of the checkboxes are checked under substance use, this checkbox will be checked

Comment [AB30]: This section is user enterable

Comment [AB31]: Repeated Table pre-fills with the Medication and Medical History from Medical/Mental window Medical History tab and Add new Medication window for the child.

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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)

Comment [AB32]: Pre-fills with the Medication name that is a Psychotropic

Comment [AB33]: Pre-fills with Dosage information for the Medication stored on the Add new Medication window

Comment [AB37]: Pre-fills with Reason For Medication textbox information for the Medication stored on the Add new Medication window

Comment [AB34]: Pre-fills with Date Medication Prescribed information for the Medication stored on the Add new Medication window

Comment [AB35]: Pre-fills with Date Medication Stopped information for the Medication stored on the Add new Medication window

Comment [AB36]: Pre-fills with Name of Prescribing Physician/Practitioner information for the Medication stored on the Add new Medication window

Comment [AB38]: Repeated Table pre-fills with the Treatment history from the Medical/Mental window's Medical history Tab's Treatment history information. Pre-fills with the Type of Service

Comment [AB39]: Pre-fills with the Service Dates First

Comment [AB40]: Pre-fills with the Service Dates Last

Comment [AB41]: User Entered

Comment [AB42]: Pre-fills with the FSFN or Other Provider whichever is stored