Florida Department of Children & Families

Clear

PSYCHIATRIC EVALUATION REFERRAL

Evaluating Physician's Name:_____

Evaluation Address:

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 or in SIPP, in which case the Referral may be filled out after the child receives medication based on information received from the hospital/SIPP). This form must also be provided to the CLS attorney, parents, guardian *ad litem* or attorney *ad litem* if one has been appointed.

If medications are prescribed, upon the doctor's completion of the Medical Treatment Plan, this Referral must be attached to the Medical Treatment Plan and both faxed to CLS. If there are any problems with the request for 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.

SECTION 1: CHILD'S INFORMATION

Child's Name:_____ DOB:_____

Child's Height:_____ Child's Weight:_____ Gender:_____

Case No.:_____ Assigned Attorney:_____ Judge:_____

SECTION 2: CONTACT INFORMATION

Case Manager:_____ Phone:_____ Email:

Case Mngr. 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:

Father: (if not terminated)_____ Phone:_____ Email:

SECTION 3: 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.

Child's Name:_____ Date:_____

SECTION 4: 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 within last _____ (number) ☐ days, ☐ weeks, ☐ months, ☐ years; or ☐ lifelong.

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

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

SECTION 5: SYMPTOMS NARRATIVE

Please describe any behaviors or symptoms of the child that have led to the request for this evaluation. In addition, include explanation of any factors checked in Section 4.

Child's Name:_____ Date:_____

SECTION 6: PSYCHOTROPIC MEDICATION and SERVICES HISTORY

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

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Medication Name	Dosage	Start Date	End Date (Reason)	Prescribing Physician and Contact Number	Reason for Medication

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