State of Illinois

CFS 417-D

7/2018

Department of Children and Family Services

**Comprehensive Diagnostic Assessment**

This form is to be completed for children 5 years old and under when an initial request is made for psychotropic medication.

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| Youth in Care Information |
| Date       | Child’s Name       | DCFS ID#       |
| [ ]  Male [ ]  Female | Date of Birth       | Race       |
| Care Giver Information |
| Name       | Phone #       |
| Address       | City       | Zip Code       |
| Case Worker Information |
| Name       | Phone #       |
| [ ]  OUTLOOK or Email       | Fax #       |
| [ ]  DCFS Office / [ ]  POS Agency       |
| Address       | City       | Zip       |
| Primary Care Physician Information |
| Name       | Phone #       |
| Email       | Fax #       |
| Address       | City       | Zip Code       |
| Presenting Problem(s) |
|       |
| Background Information, including significant medical, developmental, psychosocial, and trauma history |
|       |
| Summary of Past Mental Health Evaluation(s) |
|       |
| Summary of Past and/or Current Mental Health Treatment(s) |
|       |
| Current or Past Educational Services      |
| Assessment of the Caregiver-Child Interaction and Relationship      |

|  |  |
| --- | --- |
| Child’s Name       | DCFS ID#       |
| Developmental Assessment |
| Physical:       |
| Self-help or Daily Living Skills:       |
| Emotional (Temperament):       |
| Social:       |
| Fine and Gross Motor:       |
| Sensory Regulation and Processing:       |
| Cognitive:       |
| Communication or Language:       |
| Formulation and Diagnosis |
|       |
| Biopsychosocial Treatment Plan |
|       |
| [ ]  Already in Therapy |
| Name       | Phone #       |
| Email       | Fax #       |
| Address       | City       | Zip Code       |
| [ ]  Referral to Therapy |
| Name       | Phone #       |
| Email       | Fax #       |
| Address       | City       | Zip Code       |
| Assessment Completed by |
| Name       | Title/Degree       |
| Signature | Date | License #       |
| This form and the DCFS eHealth Passport has been sent to: [ ]  Psychiatrist [ ]  Caseworker [ ]  Primary Care Physician[ ]  DCFS Clinical Division Date Sent:     Hand deliver, fax or send via secure email to DCFS.PsychiatricReferral@illinois.gov or other recipients using the Illinois.Gov File Transfer System at: <https://filet.illinois.gov/filet/PIMupload.asp>. Follow directions to encrypt and upload files. Sender and recipients will receive a key (via email) to open the encrypted files. |