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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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](mailto: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. | | | | | | |