State of Illinois

CFS 417-E

7/2018

Department of Children and Family Services

**Request for Psychiatric Evaluation Following Therapy**

This form is to be completed by therapist for children 5 years old and under when significant symptoms persist after three months of therapy or as soon as it is determined that medication may be needed.

|  |  |
| --- | --- |
| 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       |
| Summary of Current Therapy Treatment |
|       |
| Concerning Symptoms and Behaviors |
|       |
| Form Completed by Therapist |
| Name       | Title/Degree       |
| Signature | Date | License #       |
| Referred for Psychiatric Examination for Medication |
| Psychiatrist’s Name       | Phone #       |
| Email       | Fax #       |
| Address       | City       | Zip Code       |
| THIS COMPLETED FORM INDICATES THAT A THERAPY TRIAL HAS TAKEN PLACE AND WILL NEED TO BE SUBMITTED TO THE CONSENT UNIT WITH THE MEDICATION REQUEST |
| This form 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. |