## State of Illinois Department of Children and Family Services

## **Outpatient Psychiatry Request Form**

Criteria: DCFS youth in care with mental health problems that are causing significant distress or functional impairment in their family, school or other environment. Please complete all sections of this form. You will receive a call from a Consulting Psychologist to review the information and to make the appropriate referral.

Youth in Care Information						
Date Child's Name	Date Child's Name DCFS ID#					
☐ Male ☐ Female ☐	☐ Male ☐ Female Date of Birth					
Language(s) spoken at home?		Interpreter Needed?				
Placement: ☐ Foster Care ☐ S <sub>1</sub>	pec Foster Care	Care Relative Spec Foster Care				
☐ Intact ☐ Returned Home of P	Parent Sub-guardianship	Adoption				
☐ Residential Treatment Facility	☐ TLP ☐ ILO ☐ Other					
☐ Psychiatric Hospital (if hospitalized,	, also check prior placement type abov	ve)				
Care Giver Information						
Name	Phone #					
Address	Address City Zip Code					
☐ COOK REGION (Check area below	,					
	□ North City □ South Suburban □					
	ENTRAL REGION   SOUTH	ERN REGION				
Case Worker Information		DI #				
Name		Phone #				
OUTLOOK or Email:		Fax #				
DCFS Office / POS Agency: Address		City Zip				
Supervisor		Region/Site/Field				
Reason for Referral		Region/Site/Field				
Medication Consultation/Revi	iew □ Diagnostic Clarification □	Medication Management/Treatment				
☐ Medication Consultation/Review ☐ Diagnostic Clarification ☐ Medication Management/Treatment  Presenting Problem(s) including symptoms, behaviors, duration, severity, history and any complicating factors:						
Tresenting Problem(s) meruanig sympe	ionis, cenaviors, adracion, severity, ms	tory and any complicating factors.				
Claring I Francis March I Harlet Communication						
Clinical Features/Mental Health Concerns						
Current DSM Diagnosis(es):						
DESCRIBE ANY CURRENT SAFETY ISSUES such as danger to self or others, psychotic symptoms, violent						
behaviors:						
Current Concerns:						
	Danrassian	☐ Poor Concentration				
Argan Managament James	☐ Depression					
☐ Anger Management Issues	☐ Hallucinations	Re-experiencing				
☐ Aggressive Behavior - Verbal	☐ Hopelessness/ Helplessness	Severe Mood Swings				
☐ Aggressive Behavior - Physical	☐ Hyperactivity	☐ Sleep Disturbance				
Anxiety	☐ Impulsivity	☐ Somatic Complaints				
☐ Damaging Property	☐ Insight/Judgment Problem	☐ Traumatic Grief/Separation				
☐ Decreased Energy	☐ Oppositional/Defiant	Other?				

Child's N	Vame						DCI	FS ID#	
CURRE	NT MENT	AL HEALT	H TREATME	NT					
Outpatie	nt <b>psychiat</b> ı	rist currently	seeing or 🗌 ch	eck if NONE					
Name					Date s	tarted		Estimated #	Visits
Reason f	or Visit								
Address				City/Zip			Pho	ne	
Current l	Medication(	s)	Dose	Frequency	Addit	tional Inform	mation:		
	in Treatmen	•		or No Progre			e to stressor	☐ Near Cor	npletion
			pist currently	seeing or $\square$ c				F-4: 4 - 1 #	X7: -:4 -
Name (w	ith credenti	ais)			Date s	tarted		Estimated #	VISIUS
Reason f	or Visit				I				
Address				City/Zip			Pho	ne	
Progress	in Treatmer	nt: 🔲 Impro	ved    Little	or No Progre	ss 🔲 Re	egressed du	e to stressor	☐ Near Cor	npletion
Alcohol/	Substance	Use?							
□ None	☐ Yes, inc	dicate type, fr	equency, durat	ion					
HISTOR	RY OF ME	NTAL HEAI	TH TREATN	IENT or □ c	heck if N	ONE			
Any Med	dication(s), p	osychiatrists,	outpatient thera	apists within p	ast two y	ears that is	not listed abo	ove:	
Inpatient Treatment or □ check if NONE									
				ations:	☐ 1 – 3	<u> </u>	6	-9 □>i	10
Total Number of Inpatient Psychiatric Hospitalizations: $\Box 1-3$ $\Box 4-6$ $\Box 7-9$ $\Box >10$ <b>Exposure to Trauma History If YES, describe</b>									
☐ Yes	□No	Sexual Abu	se		☐ Yes	□No	Domestic V	Violence	
☐ Yes	□No	Physical At	ouse		☐ Yes	□No	Victim Cri	minal Activity	7
☐ Yes	□No	Emotional A	Abuse		☐ Yes	□No	Parental/Fa	mily Crimina	l Activity
☐ Yes	□ No	Child Negle	ect		☐ Yes	□No		y/School Viole	•
☐ Yes	□No	Medical Tra			☐ Yes	□No		Manmade Dis	
Describe Trauma History:									
2-20-100 1-10-10-10-10-10-10-10-10-10-10-10-10-10									
REFER	REFERRAL from (check all that apply)   Caseworker Caregiver Pediatrician Therapist School						School		
	☐ Integrated Assessment ☐ Integrated Assessment with Screener ☐ CAYIT Staffing ☐ Help Unit								
☐ Family Team Meeting ☐ Clinical Staffing ☐ Psychological Evaluation ☐ Court Order ☐ Court Request									

DO NOT WRITE ON THIS PAGE – FOR CONSULTING PSYCHOLOGY USE ONLY This form will be returned to the referring caseworker with the information below completed.							
11	nis form Will	be retu	rnea to the reterrin	ig caseworker wit	n tne infor	mation below completed.	
CONTACT	'S:						
☐ Phone	☐ Email	Date:		☐ Phone	Em 🗆 Em	ail Date:	
☐ Phone	☐ Email	Date:		☐ Phone	Em.	ail Date:	
☐ Phone	☐ Email	Date:		☐ Phone	Em.	ail Date:	
RESPONSI	E:						
☐ Accepted	for Referral		Referral Clinic:	Clinic: Location:			
Please take	this entire for	m to the	first appointment.				
	☐ Unable to Contact (attempts listed above)						
☐ Information reviewed and available services do not meet the needs of the child; Recommendations:							
☐ Patient Declined Service; Reason:							
Expiration Date: Referral duration is <b>6 Months</b> ; after that a new form needs to be submitted							
Consultant:				Date:		Consult Review #	