

Child's Name				DCFS ID#	
CURRENT MENTAL HEALTH TREATMENT					
Outpatient psychiatrist currently seeing or <input type="checkbox"/> check if NONE					
Name		Date started		Estimated # Visits	
Reason for Visit					
Address		City/Zip		Phone	
Current Medication(s)	Dose	Frequency	Additional Information:		
Progress in Treatment: <input type="checkbox"/> Improved <input type="checkbox"/> Little or No Progress <input type="checkbox"/> Regressed due to stressor <input type="checkbox"/> Near Completion					
List outpatient psychologist/therapist currently seeing or <input type="checkbox"/> check if NONE					
Name (with credentials)		Date started		Estimated # Visits	
Reason for Visit					
Address		City/Zip		Phone	
Progress in Treatment: <input type="checkbox"/> Improved <input type="checkbox"/> Little or No Progress <input type="checkbox"/> Regressed due to stressor <input type="checkbox"/> Near Completion					
Alcohol/Substance Use?					
<input type="checkbox"/> None <input type="checkbox"/> Yes, indicate type, frequency, duration					
HISTORY OF MENTAL HEALTH TREATMENT or <input type="checkbox"/> check if NONE					
Any Medication(s), psychiatrists, outpatient therapists within past two years that is not listed above:					
Inpatient Treatment or <input type="checkbox"/> check if NONE					
Total Number of Inpatient Psychiatric Hospitalizations: <input type="checkbox"/> 1 – 3 <input type="checkbox"/> 4 – 6 <input type="checkbox"/> 7 – 9 <input type="checkbox"/> >10					
Exposure to Trauma History If YES, describe					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexual Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Domestic Violence
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Physical Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Victim Criminal Activity
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emotional Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parental/Family Criminal Activity
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Child Neglect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Community/School Violence
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medical Trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Natural or Manmade Disaster
Describe Trauma History:					
REFERRAL from (check all that apply) <input type="checkbox"/> Caseworker <input type="checkbox"/> Caregiver <input type="checkbox"/> Pediatrician <input type="checkbox"/> Therapist <input type="checkbox"/> School <input type="checkbox"/> Integrated Assessment <input type="checkbox"/> Integrated Assessment with Screener <input type="checkbox"/> CAYIT Staffing <input type="checkbox"/> Help Unit <input type="checkbox"/> Family Team Meeting <input type="checkbox"/> Clinical Staffing <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Court Order <input type="checkbox"/> 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.

CONTACTS:

<input type="checkbox"/> Phone	<input type="checkbox"/> Email	Date:	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	Date:
<input type="checkbox"/> Phone	<input type="checkbox"/> Email	Date:	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	Date:
<input type="checkbox"/> Phone	<input type="checkbox"/> Email	Date:	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	Date:

RESPONSE:

<input type="checkbox"/> Accepted for Referral	Referral Clinic:	Location:
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Please take this entire form 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 **6 Months**; after that a new form needs to be submitted

Consultant:	Date:	Consult Review #
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