EVALUATION REFERRAL FORM FOR PSYCHOTROPIC MEDICATION

Evaluating Physician's Name: _____

_____

Evaluation Address: _____

_____

Date/Time of Scheduled Eval: _____

Case Manager Instructions: This Referral must be completed for all psychotropic medication evaluation requests. This Referral must be provided to the physician prior to the child's evaluation (unless the child is hospitalized or in SIPP, in which case the Referral may be filled out after the child receives medication based on information received from the hospital/SIPP). This form must also be provided to the CLS attorney, parents, guardian *ad litem* or attorney *ad litem* if one has been appointed.

If medications are prescribed, upon the doctor's completion of the Medical report for children on psychotropic medication, this Referral must be attached to the Medical report and both faxed to: CLS If there are any problems with the request for medication, CLS will notify the case manager and the CBC in order to quickly remedy the problem. CLS may also attempt to contact the physician directly.

SECTION 1: CHILD'S INFORMATION

Child's Name: _____ DOB: _____

Child's Height: _____ Child's Weight: _____

Case No.: _____ Assigned Attorney: _____ Judge: _____

SECTION 2: CONTACT INFORMATION

Case Manager: _____ Phone: _____ Email: _____

Case Manager Supervisor: _____ Phone: _____ Email: _____

Contracted Agency: _____ Phone: _____ Email: _____

Caregiver (if not confidential): _____ Phone: _____ Email: _____

Therapist name: _____ Phone: _____ Email: _____

Primary care phys. name: _____ Phone: _____ Email: _____

Treating psychiatrist name: _____ Phone: _____ Email: _____

GAL name (if assigned): _____ Phone: _____ Email: _____

School name: _____ Phone: _____ Email: _____

Mother (if not terminated): _____ Phone: _____ Email: _____

Father (if not terminated): _____ Phone: _____ Email: _____

SECTION 3: AVAILABLE DOCUMENTS, PRIOR REPORTS. Please list all known prior evaluations or reports on the child. Include dates. Ex: psychiatric, psychological, mental health assessment, CPT, forensic interviews, etc. Please ATTACH any evaluation that specifically requested this evaluation.

SECTION 4: CHILD HISTORY, BACKGROUND
Please check all that apply to this child.

☐ history of substance abuse

☐ history of non-compliance with medications

☐ history of psychiatric hospitalization/residential treatment center

☐ currently placed in psychiatric hospital/residential treatment center

☐ history of violence or threats of violence (to self or others)

☐ depression

☐ social or developmental delays

☐ other_____

☐ Specific suicidal statements or actions

☐ Traumatic experiences

☐ prior psychiatric diagnoses

☐ current non-psychiatric medical condition

☐ recent change in mood or behavior

☐ family mental health history

☐ family history of substance abuse

☐ family history of domestic violence

☐ academic or social difficulties

Symptoms began within last _____ (number) ☐ days, ☐ weeks, ☐ months, ☐ years; or ☐ lifelong.

Who has reported the symptoms? ☐ the child, ☐ placement, ☐ school, ☐ physician, ☐ parent,

☐ case manger, ☐other(please list)_____

History of abuse: ☐ abandonment, ☐ neglect, ☐ physical, ☐ sexual, ☐ emotional.

SECTION 5: SYMPTOMS NARRATIVE
Please describe any behaviors or symptoms of the child that have led to the request for this evaluation. In addition, include explanation of any factors checked in Section 4.

SECTION 6: PSYCHOTROPIC MEDICATION and SERVICES HISTORY

List below or attach a list of all known medications that the child has taken or *is taking* at the time this referral is being made. Also list below or attach all psycho-social services (including therapy, CBAs, and any school services) the child has received. Repeat page as necessary.

MEDICATION NAME	DOSAGE	START DATE	END DATE (REASON)	PRESCRIBING PHYSICIAN & CONTACT NUMBER	Reason for Medication

SERVICE/THERAPY	START DATE	END DATE	FREQUENCY	PROVIDER'S NAME & PHONE NUMBER (if known)