Diagnostic Assessment Form

SCDE-DA-Form – 7-2016

This information will only be used as a part of a comprehensive evaluation of the child.

Procedure Code:

Date of Assessment:			**M** **F**
Student's Name		**Date of Birth** **Age** **Race**	**Sex**
Grade			
Social Security # **Medicaid #**		**School Name** **Phone#**	
Parent/Guardian Name **Last Name**		**Home Phone#**	**Work Phone#**
Address		**Insurance Information:**	
City **Street** **Zip Code**		**Date of Admission / Start Date RBHS**	**Follow-up Assessment**
Emergency Contact Name **Relationship**		**Home Phone#**	**Cell Phone#**
Preferred Language:			

Biological Parent History

Parent Relationship: (Check One) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Remarried** ☐ **Separated**

Mother Name		**Father Name**

Legal Guardian Family History

Legal Guardian Name		**Relationship to student**
Child Adopted **Date/Year**		**Child in Legal Custody of**
Foster Care **Date/Year**		**Caseworker Name**
County **State**		**Caseworker #**

List of everyone who lives in the home:		**Language Spoken in the home:**
Name **Age**		**Relationship**
Name **Age**		**Relationship**
Name **Age**		**Relationship**
Name **Age**		**Relationship**

Reason for Referral for The Diagnostic Assessment:

Presenting Complaint/Reason for Referral/Reason for Assessment/Reason for Continued Services:

Family Issues:

Please describe any significant changes or ongoing problems in the family or home environment that may have affected the child's behavior.

Have any of the blood relatives on the child's mother or father's side (including siblings) ever had Behavioral Health problems similar to those the child has? If so, describe:

Describe any problematic child relationship with immediate and/or extended family members.

Does the child have positive influences or relationships with immediate and extended family members?

Is the child being placed outside the home due to family issues? ☐ Yes ☐ No

Comment(s)

List Student's Medical History to include (List all Medications):

Is the child in good health? ☐ **Yes** ☐ **No** **Allergies?** ☐ **Yes** ☐ **No** **List Allergy Medication:**

Family Doctor: **Phone #:** **Date of last physical:**

If the child's history includes any of the following problems please indicate the problem with a √ mark.

Problem:					
Sleep	☐	**Pneumonia**	☐	**Chronic cold**	☐
Eye	☐	**High BP**	☐	**Allergies**	☐
Ear infection	☐	**Headaches**	☐	**Asthma**	☐
Diabetes	☐	**Appetite**	☐	**Tonsillectomy**	☐
Measles	☐	**TB**	☐	**Adenoidectomy**	☐
Scarlet Fever	☐	**Kidney**	☐	**Blackouts**	☐
Rheumatic fever	☐	**Liver**	☐	**Glandular disturbance**	☐
Mumps	☐	**lungs**	☐	**Extreme fatigue**	☐

Problem/Date					
Head injury	☐	**Intestinal**	☐	**Bipolar**	☐
Body injury	☐	**Immune**	☐	**Anxiety**	☐
Convulsions	☐	**Hep B**	☐	**Intellectual**	☐
Seizures	☐	**Hep C**	☐	**Disabilities**	
Sickle cell	☐	**ADHD**	☐	**Birth Defects**	☐
Thyroid	☐	**CD**	☐	**Autism**	☐
Cancer	☐	**OD**	☐		☐
Stomach	☐	**Depression**	☐	**[Other]**	☐

Describe any surgery the child has had:

MD Specialist: Phone: Last Visited:

Describe any other serious illnesses, accident, falls, or deformities not already mentioned:

Current Medication prescribed for child: Dosage, frequency, reason for Rx

Rx 1:	**Dosage:**	**Frequency:**
Reason for Rx:	**How long on Rx:**	**Does Rx Work:**
Rx 2:	**Dosage:**	**Frequency:**
Reason for Rx:	**How long on Rx:**	**Does Rx Work:**
Rx 3:	**Dosage:**	**Frequency:**
Reason for Rx:	**How long on Rx:**	**Does Rx Work:**

List previous Medications prescribed for child: Dosage, frequency, reason for Rx

Rx 1:	**Dosage:**	**Frequency:**
Reason for Rx:	**How long on Rx:**	**Did Rx Work:**
Rx 1:	**Dosage:**	**Frequency:**
Reason for Rx:	**How long on Rx:**	**Did Rx Work:**

Mental Health History:

Is the child deemed to be at risk of psychiatric hospitalization or out-of-home-placement? ☐ Yes ☐ No

Comment(s)

In the last 90 days has the child exhibited behavior(s) that included at least one intervention by crisis response, social services, or law enforcement? ☐ Yes ☐ No

Comment(s)

Frequency of behavior in the past 3 months: ☐ Daily ☐ 3-4 times a week ☐ at least 10 times a month ☐ Other

At what age did these behaviors begin?

Has the child ever received Mental Health Treatment in the Past: ☐ Yes ☐ No
If yes please complete the table below.

Attach any medical documentation, if applicable.

In/Out Patient Treatment	Location	Date of Treatment	Diagnosis	Type of Treatment

Comments:

Relationships with Other Children:

How well does the child get along with siblings (brothers/sisters)? ☐ Excellent ☐ Good ☐ Poor

Does the child seek friendships with other children? ☐ Yes ☐ No ☐ Sometimes

Is the child sought by other children for relationships? ☐ Yes ☐ No ☐ Sometimes

Does the child play primarily with other children ☐ his or her own age? ☐ Younger? ☐ Older?

Does the child participate in group activities? ☐ Yes ☐ No ☐ Sometimes

List the Sports/Club/Extracurricular activities?

What does the child do for fun?

What does the child do to relax or calm down? (comment)

Social and Cultural Concerns:

Where was the child born?

Is there anyone who may assist the parent with raising the child or has significant relationship with the child? ☐ Yes ☐ No If yes, please explain:

Does the child have problems with any of the following: Please explain:

Gender Identity? ☐ Yes ☐ No If yes, please explain

Sexual Orientation? ☐ Yes ☐ No If yes, please explain

Spiritual Beliefs? ☐ Yes ☐ No If yes, please explain

Child's Concerns:

Does the child have any other issues or concerns or worries that were not asked already during interview?

☐ Yes ☐ No If yes, please explain:

What else is important that the child wants to report?

What would the child like to see happen or change because of services?

Academic History:

Rate the child's school experience related to academic learning as: ☐ Good ☐ Average ☐ Fair ☐ Poor

Type of Class: ☐ Regular ☐ Mainstream ☐ Special-Ed

Did the child have trouble learning with: ☐ Reading ☐ Written Language ☐ Mathematics

Has the child ever had to repeat a grade? If so, which grade(s)?

Need for discipline: ☐ None ☐ infrequent ☐ Frequent

Office referrals ☐ ISS ☐ OSS ☐ Expulsions ☐ Detention

Attendance: ☐ Regular attendance ☐ Misses often/excused ☐ Misses often/unexcused

Reason for absences: ☐ Illness ☐ Truancy ☐ Other, specify:

Please list any other schools the child has attended this year:

School:	Grade Attended:
City:	State:
School:	Grade Attended :
City:	State:
School:	Grade Attended :
City:	State:
Comment about previous school and list the child's favorite subjects:	
Rate the child's school experience related to behavior as: Good Average Fair or Poor:	
Elementary: ☐ Good ☐ Average ☐ Fair ☐ Poor	
Middle: ☐ Good ☐ Average ☐ Fair ☐ Poor	
High School: ☐ Good ☐ Average ☐ Fair ☐ Poor	
What other agencies are involved with this student?	
☐ Juvenile Court Involvement ☐ Department of Social Services ☐ Mental Health ☐ Others:	
If yes to any of the above please explain:	
Does the child get along with teachers? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never	
Explain:	
Does the child like school? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never	
Explain:	
Describe briefly any other classroom behavioral problems:	

Justification for Authorization - Risk Factors that interfere with the ability to function in a daily living, personal relationships, school and recreational settings that will assist in determining medical necessity for services or the need for an additional assessment or referral for services.

Behavioral Health / Mental Health Risk Factors

Risk Factor	Check if Applicable	Level of Severity
Regression in self-care skills	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Bullying from others in school	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Inability to attend school without support	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Regression in age appropriate skills	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Lack of Parental Guidance	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Fighting in school	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Alternative Educational Placement	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
School Suspension or Expulsion	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Home Bound Suspension	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Defiance, violation of rules	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Discipline by ISS or OSS	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Involved with Law Enforcement	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low
Involved with a Child Placement Agency	☐ Yes ☐ No	☐ High ☐ Mod ☐ Low

Other Behavioral Health /Mental Health Risk Factors

List more than one descriptor, if applicable. Elaborate on any problem areas in the space provided.

Appearance & Hygiene	☐ Meticulous ☐ Neat ☐ Clean ☐ Disheveled ☐ Bizarre ☐ Body Odor Comments:
Motor Activity	☐ Appropriate to situation ☐ Over-active ☐ Tremor ☐ Tics ☐ Poor coordination ☐ Repetitive ☐ Lethargic Comments:
Attitude During Interview	☐ Cooperative ☐ Oppositional Hostile ☐ Dramatic ☐ Guarded ☐ Irritable ☐ Withdrawn ☐ Silly Comments:
Affect	☐ Appropriate to situation ☐ Blunted ☐ Flat ☐ Tearful ☐ Incongruent ☐ Expansive ☐ Labile Comments:
Mood	☐ Happy ☐ Euthymic ☐ Anxious ☐ Depressed ☐ Angry ☐ Hopeless ☐ Suspicious ☐ Passive Comments:
Speech	☐ Normal Rate and tone ☐ Slow ☐ Fast ☐ Soft ☐ Loud ☐ Pressured ☐ Slurred ☐ Stuttering ☐ Alogia Comments:
Hallucinations	☐ No Auditory ☐ Command ☐ Visual ☐ Olfactory ☐ Tactile ☐ Denies Comments:
Orientation/Level of Consciousness	☐ Alert ☐ Oriented to ☐ Person ☐ Place ☐ Time ☐ Situation ☐ Clouded ☐ Confused Comments:
Judgment	☐ Able to make sound decisions ☐ Usually able to make sound decisions ☐ Poor decision making, adversely affects self ☐ Poor decision making, adversely affects others Comments:
Memory (use example)	☐ Intact ☐ Poor remote ☐ Poor recent ☐ Poor immediate Comments:

Justification for Authorization - Risk Factors that interfere with the ability to function in a daily living, personal relationships, school and recreational settings that will assist in determining medical necessity for services or the need for an additional assessment or referral for services.

Check applicable boxes and enter a code by the "T"= Time for when the behavior was last exhibited: 24=within last 24 hours, ds=few days, w=last 7 days or week, m=last 30 days or month.

Homicide Risk Assessment:

Experienced persistent ideation:	☐ Yes	☐ No	T:
Made threats to harm others:	☐ Yes	☐ No	T:
Made gestures to harm others:	☐ Yes	☐ No	T:
Engaged in rehearsing homicidal acts:	☐ Yes	☐ No	T:

Suicide Risk Assessment:			
Made an attempt of suicide:	☐ Yes	☐ No	T:
Made threats to harm self:	☐ Yes	☐ No	T:
Talked with a therapist or other staff about suicide intentions/thoughts:	☐ Yes	☐ No	T:
Made a clear statement of intent to others:	☐ Yes	☐ No	T:
Has written a suicide note :	☐ Yes	☐ No	T:
Described a practical/available method or plan:	☐ Yes	☐ No	T:
Has given away an important personal possession:	☐ Yes	☐ No	T:
Established access to means/methods:	☐ Yes	☐ No	T:
Self-Mutilation:	☐ Yes	☐ No	T:
Other Risky Behaviors (specify):			
Gang affiliations:	☐ Yes	☐ No	T:
Fire setting:	☐ Yes	☐ No	T:
History of violence:	☐ Yes	☐ No	T:
Violence towards animals:	☐ Yes	☐ No	T:
Urgent risk for:	Homicide ☐ Yes ☐ No	Suicide ☐ Yes ☐ No	
Actions taken based on Urgency:			

Justification for Authorization - Risk Factors that interfere with the ability to function in a daily living, personal relationships, school and recreational settings that will assist in determining medical necessity for services or the need for an additional assessment or referral for services.

Trauma History		
Exposure to Physical Abuse, Sexual Abuse, Anti-Social Behavior, or Other Traumatic Events:		
History of trauma: ☐ Yes ☐ No		
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Sexual	Signs Reported: ☐ None ☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Physical	Signs Reported: ☐ None • ☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Emotional	Signs Reported: ☐ None ☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Mental	Signs Reported: ☐ None ☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Accident	Signs Reported: ☐ None ☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Natural Disaster	Signs Reported: ☐ None ☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim	☐ Violence	Signs Reported: ☐ None

☐ Witness ☐ Perpetrator		☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Neglect	Signs Reported: ☐ None ☐ Symptoms ☐ Denies ☐ Acknowledges
Child was a: ☐ Victim ☐ Witness ☐ Perpetrator	☐ Other Type of Abuse -explain	Signs Reported: ☐ None ☐ Symptoms ☐ Denies ☐ Acknowledges
Describe Issues Identified: ☐ Nightmares ☐ Flashbacks ☐ Startle Reflex ☐ Avoidance ☐ Anger ☐ Depression ☐ Anxiety		
Comments:		

History of Substance Use: ☐ Yes ☐ No

Alcohol: ☐ Beer ☐ Wine/Wine Cooler ☐ Liquor ☐ 100% Proof Alcohol How much?_____ How often? _____
Cannabis: ☐ Joint ☐ Blunt ☐ Other_____ How much? _____ How often? _____
Sedatives: ☐ Xanax ☐ Klonopin ☐ Ativan ☐ Ecstasy ☐ Valium ☐ Other_____ How much? _____ How often? _____
Stimulants: ☐ Crack ☐ Cocaine ☐ Methamphetamine ☐Speed ☐ Other_____ How much?_____ How often? _____
Hallucinogens: ☐ LSD ☐ Mushrooms ☐ Mescaline ☐ Other_____ How much? _____ How often? _____
Opiates: ☐ Heroin ☐Codeine ☐ Morphine ☐ Percocet ☐ Oxycodone ☐ Other_____ How much? _____ How often? _____
Inhalants: ☐ Gasoline ☐ Kerosene ☐ Nail Polish Remover ☐ Aerosol Spray ☐ Computer Cleaning ☐ Duster How much? _____ How often? _____
Nicotine: ☐ Cigarettes ☐ Snuff ☐ Chewing Tobacco or Other How much? _____ How often?_____
Others Substance Use: ☐ Yes ☐ No If yes, please specify:
Experience blackouts? ☐ Yes ☐ No; if yes, describe
Withdrawal symptoms (seizures, DT's etc.) ☐ Yes ☐ No; if yes, describe
Legal involvements related to substance use? ☐ Yes ☐ No; if yes, describe
Is alcohol/drug use something that needs to be addressed in treatment? ☐ Yes ☐ No If yes, please describe.
Family History of substance abuse? ☐ Yes ☐ No; if yes, describe

Functional Assessment (with age-appropriate expectations):

List the Assessment Tool(s) and results:

DSM-5 CODE or ICD-10 CODE (Must Include Both code and Description)

DSM-5 Code: **ICD-10 Code:** **Description:**

DSM-5 Code: **ICD-10 Code:** **Description:**

DSM-5 Code: **ICD-10 Code:** **Description:**

Treatment recommendation, if applicable: Describe or list the type of services and why the services are medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Medical records on student substantiate the need for services, include all finding and information supporting medical necessity, and entail all treatment provided. See attachment for additional risk factors.

Recommended Services	Frequencies

Attach additional notes and reports: (Behavior Health Screening, if applicable)

If a referral for Psychological testing is needed, list the reason(s) below. An LPHA must make the referral for the test. The Psychological testing PA form must be submitted to the MCO for approval before the test is administered.

Is there a need to refer Behavioral Health services to an outside organization? yes ☐ no ☐

What type of referral will be made? ☐ Mental Health ☐ Private Provider ☐ Parent will Decide

Will a behavioral health plan be written? ☐ Yes ☐ No

Comment:

MHP Staff Name: **MHP Signature:** **Date**:_____

LPHA Name: **LPHA Signature:** **Date**:_____

If the DA is used for Medical Necessity-**STATE AGENCY**