Mental Health & Medical Information from Outside Agencies

Instructions: This form may only be completed by a Licensed Mental Health Clinician or a licensed health care provider (RN, MD). Prior to acceptance, a "Yes" answer on this form shall be referred to the designated mental health clinician and/or health care provider for review.

Name: _____ DOB: _____

1. Within the past two years, has a formal, written mental health evaluation been completed? If yes, attach evaluation. ☐ Yes ☐ No

2. Most recent diagnosis (Include the most recently published edition of the DSM V name of the disorder in order of impact on the youth's functioning).

   Primary diagnosis: _____

   _____

   Secondary diagnoses: _____

   _____

   _____

   _____

   _____

3. Does the youth have any medical/physical problems? If yes, describe below and provide physician's contact information. ☐ Yes ☐ No

   _____

   _____

   _____

   _____

   Physician's Name: _____ Physician's Contact Number: _____

4. Has the youth required any of the following:

   a. Voluntary or involuntary treatment in a mental health setting? (Psychiatric hospital, residential mental health placement). **Past Six Months?** ☐ Yes ☐ No **Ever?** ☐ Yes ☐ No
   If yes, provide dates and attach discharge summaries. _____

   _____

   _____

   _____

   _____

   b. Services of the regional center for a developmental disorder? **Past Six Months?** ☐ Yes ☐ No **Ever?** ☐ Yes ☐ No
   If yes, describe type/date/reason. _____

   _____

   _____

   _____

   _____

   c. Use of soft restraints for psychiatric reasons/emergency medications in last 12 months? **Ever?** ☐ Yes ☐ No
   If yes, describe type/date/reason. _____

   _____

   _____

   _____

   _____

   d. Treatment for serious, active danger to self/others due to mental illness? **Past Six Months?** **Ever?**

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☐ Yes ☐ No ☐ Yes ☐ No

If yes, list all incidents by date/type. Attach additional sheet if necessary. _____

e. Evaluation and treatment for serious impairment of functioning in most domains (i.e. thinking abilities, emotional control, judgment, relationships with others, grooming, and ability to make good use of food, clothing, and shelter in current placement).

Past Six Months? ☐ Yes ☐ No **Ever?** ☐ Yes ☐ No

If yes, describe. _____

f. Treatment of a mental illness using psychotropic medications?

Past Six Months? ☐ Yes ☐ No **Ever?** ☐ Yes ☐ No

If yes, describe. _____

5. Is the youth currently taking medication for a medical or mental health diagnosis? ☐ Yes ☐ No
If currently on medication and a court order was obtained, please attach a copy of JV220 and JV223.

6. If taking medication, please describe current medication regimen (medication, dose, frequency). _____

7. Has the youth been non-compliant with medication for a medical or mental health diagnosis?

Past Six Months? ☐ Yes ☐ No **Ever?** ☐ Yes ☐ No

If yes, describe. _____

8. Response to current pharmacologic treatment. _____

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Name: _____ DOB: _____ County: _____

9. Diagnoses associated with use of medications. _____

10. Classes of medications and length of time prescribed in the past. _____

Print Name/Title of Licensed Mental Health Provider	Print Name/Title of Health Care Provider
Signature of Licensed Mental Health Provider	Signature of Health Care Provider
Representing	Representing
Contact Phone Number	Contact Phone Number
Date	Date