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| **Mental Health Assessment Form** **Unaccompanied Children’s Program****Office of Refugee Resettlement (ORR)** |
| **General Information** |
| **Child** | Last name: | First name: |
| DOB:  | A#: | Gender: | Date evaluated: |  Time evaluated: |
| Primary language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Who provided appropriate language services for child during evaluation? | * HCP fluent in child’s primary language
 | * Trained interpreter
 | * Not provided
 |
| **Evaluating Healthcare Provider (HCP)** | Name:  **MD / DO / PA / NP / PhD / PsyD**  | Phone number: | Clinic or Practice:  |
| Street address: | City/Town: | State:  |
| Location where child received care (e.g., Psychiatrist/Psychiatric NP or PA visit, Psychologist visit): |
| **Program**  | Program name:  | * Program Staff Member Present During Exam with HCP
 |
| **Reason for visit:** | * Initial specialist visit
 | * Follow-up specialist visit
 |
| **History and Assessment**  |
| **Vital Signs** |
| **Temperature (T)** | **Heart Rate (HR)** | **BP (> 3 yrs)** | **Resp Rate (RR)** | **Height (HT)** | **Weight (WT)** | **BMI (>2 yrs)** | **BMI %ile** |
|   0C |  |  |  |  cm  |  kg  |  |  |
|  **Allergies:**  | * No
 | * Yes, specify below:
 |
|  | **Food** | **Medication** | **Environmental** |
| Allergen |  |  |  |
| Reaction |  |  |  |
| **Medical & Mental Health History (including dates & locations of care):** |
| Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Chronic/Underlying conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medications, (dosage frequency & dates):** | * Past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Current: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Reproductive history (complete for anatomically female UC who have started menarche):**  |
| Date of LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_, if unknown, months since LMP: \_\_\_\_\_\_ | * Current contraceptive use
 | * Currently breastfeeding
 |
| **Abuse:** | * Yes, specify
 | * Denied, with no obvious signs
 | * Denied, but obvious signs present
 | * Unknown
 |
| * Verbal:
 |
| * Emotional:
 |
| * Physical:
 |
| * Sexual:
 |
| * Other victimization (e.g., gang, bullying, crime):
 |
| **Substance use:** | * Yes, specify
 | * Denied, with no obvious signs/symptoms
 | * Denied, but obvious signs/symptoms present
 | * Unknown
 |
|  | **Alcohol** | **Tobacco / Nicotine** | **Marijuana** | **Injection drugs** | **Other substances** |
| Specify substance(s) |  |  | N/A |  |  |
| Frequency/Quantity |  |  |  |  |  |
| Date of last use |  |  |  |  |  |
| **Review of Systems (ROS) and Mental Status Exam (MSE)** |
| **Were any mental health signs/symptoms reported by the child or observed by program staff or HCP?** | * No
 | * Yes, specify below:
 |
| * Feels empty, hopeless, sad, numb more often than not
 | * Engages in self-harm
 | * Other:
 |
| * Feels constantly worried, anxious, nervous more often than not
 | * Feels easily annoyed or irritated
 |
| * Has trouble concentrating, restless, too many thoughts
 | * Relives traumatic events from the past
 |
| * Experiences mood swings, from very high to very low
 | * Feels afraid, easily startled, jumpy
 |
| * Hears voices or sees things others do not see (hallucinations)
 | * Thoughts of hurting self, would be better dead
 |
| * Has trouble eating, sleeping
 | * Thoughts of hurting others
 |
| * Has nightmares
 |
| Can child attribute feelings to a specific reason(s)? | * No
 | * Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **Brief Mental Status Exam (MSE)** |
|  | **Normal** | **Abnormal, specify:** |
| Appearance | * Normal grooming & hygiene
 |  |
| Attitude | * Calm & cooperative
 |  |
| Behavior | * No unusual movements or psychomotor changes
 |  |
| Speech | * Normal rate/tone/volume without pressure
 |  |
| Affect | * Reactive & mood congruent; good range
 |  |
| Mood | * Euthymic
 |  |
| Thought processes | * Goal-directed & logical
 |  |
| Thought content | * Not passive/active suicidal/homicidal
 |  |
| Perception | * No hallucinations or delusions during interview
 |  |
| Orientation | * Oriented time/place/person/ self
 |  |
| Memory/ Concentration | * Short and long term intact
 |  |
| Insight/Judgement | * Good
 | * Fair
 | * Poor
 |

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| --- |
| **Diagnosis and Plan** |
| **Diagnosis:** Child with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: | * No
 | * Yes
 |
| If **Yes**, check all diagnoses that apply. Specify in the space provided, where indicated. |
| **DSM:** | * Acute stress disorder/PTSD
 | * ADHD
 | * Adjustment disorder
 | * Autism
 | * Bipolar disorder
 |
| * Conduct disorder
 | * Eating disorder
 | * Generalized anxiety disorder
 | * Major depressive disorder
 |
| * Oppositional defiant disorder
 | * Panic disorder
 | * Primary psychotic disorder
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Medical:** |  |
|  |
| **Plan:** Check all that apply and specify where indicated. Please provide copies of office notes and lab/imaging results to program staff. |
| * Age-appropriate anticipatory guidance discussed and/or handout given
 |
| * Child educated on healthcare services received and treatment recommendations
 |
| * Labs/imaging ordered/performed
 |
| * Medications administered/prescribed:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medication Name | Reason | Date Started | Expected end date | Dose | Directions | Psychotropic |
|  |  |  |  |  |  | * No
 | * Yes
 |
|  |  |  |  |  |  | * No
 | * Yes
 |
|  |  |  |  |  |  | * No
 | * Yes
 |

 |
| * Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency:
 |
| * Onsite care provider clinician evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Increased level of supervision for mental health concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Placement at a residential treatment center (RTC)[[1]](#footnote-2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Assistance with daily living activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Child has/may have an ADA disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Child has health concerns that require follow-up services; specify needs and time frame by when services should occur:
 |
| * Return clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Mental health specialist evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Child cleared to travel:** | * Yes, with no restrictions
 |
| * Yes, with restrictions (e.g., ground travel, travel safety plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * No, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Recommendations from Healthcare Provider / Additional Information** |
|  |
| **Recommendations from Healthcare Provider / Additional Information** |
|  |
| **Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_****Healthcare Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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1. Requires the recommendation of a psychiatrist or clinical psychologist [↑](#footnote-ref-2)