OMB Control No: 0970-0466
Expiration date: XX/XX/XXXX

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
°C				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
- Feels constantly worried, anxious, nervous more often than not
- Has trouble concentrating, restless, too many thoughts
- Experiences mood swings, from very high to very low
- Hears voices or sees things others do not see (hallucinations)
- Has trouble eating, sleeping
- Has nightmares
- Engages in self-harm
- Feels easily annoyed or irritated
- Relives traumatic events from the past
- Feels afraid, easily startled, jumpy
- Thoughts of hurting self, would be better dead
- Thoughts of hurting others
- Other: _____

Can child attribute feelings to a specific reason(s)? • No • Yes, specify: _____

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	

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]: _____
€ 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

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[1] Requires the recommendation of a psychiatrist or clinical psychologist

Healthcare Provider Signature: _____ **Date:** _____ / _____ / _____

Healthcare Provider Printed Name: _____

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