

## Mental Health Assessment Form Unaccompanied Children's Program Office of Refugee Resettlement (ORR)

### General Information

<b>Child</b>	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
<b>Evaluating Healthcare Provider (HCP)</b>	Name: <span style="font-size: small;">MD / DO / PA / NP / PhD / PsyD</span>		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):						
<b>Program</b>	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: \_\_\_/\_\_\_/\_\_\_, • Approximate • Exact • Contraceptive use, specify: \_\_\_\_\_ • 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:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Feels empty, hopeless, sad, numb more often than not</li> <li>• Feels constantly worried, anxious, nervous more often than not</li> <li>• Has trouble concentrating, restless, too many thoughts</li> <li>• Experiences mood swings, from very high to very low</li> <li>• Hears voices or sees things others do not see (hallucinations)</li> <li>• Has trouble eating, sleeping</li> <li>• Has nightmares</li> </ul> | <ul style="list-style-type: none"> <li>• Engages in self-harm</li> <li>• Feels easily annoyed or irritated</li> <li>• Relives traumatic events from the past</li> <li>• Feels afraid, easily startled, jumpy</li> <li>• Thoughts of hurting self, would be better dead</li> <li>• Thoughts of hurting others</li> </ul> |
|---|---|

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)<sup>1</sup>: \_\_\_\_\_
- € 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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<sup>1</sup> Requires the recommendation of a psychiatrist or clinical psychologist

**Healthcare Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Healthcare Provider Printed Name:** \_\_\_\_\_

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