OMB Control No: 0970-0509
Expiration date: 09/30/2026

# Mental Health Assessment Form
# Unaccompanied Alien Children Bureau
# Office of Refugee Resettlement (ORR)

## General Information

**Child**

Last name: | First name:

DOB: | A#: | Sex: | 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: ____ / ____ / _____, • 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:

- 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**

**Recommendations from Healthcare Provider / Additional Information**

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

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

**Healthcare Provider Printed Name:** _____