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
^{0}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: ____

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to provide ORR with critical health information for u
children in the care of ORR. Public reporting burden for this collection of information is estimated to average 11 minutes per healthcare provider, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (6 U.S.C. §279: Exhibit 1, part A.2 of the Flores Settlement Agreement (Jenny Lisette Flores, et al., v. Janet Reno, Attorney General of the United States, et al., Case No. CV 85-4544-RJK [C.D. Cal. 1996]). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0466 and the expiration date is 09/30/2026. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.