

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

Instructions: This entire form must be completed by the evaluating licensed mental health provider by the conclusion of every scheduled assessment. Please refer to the MHAF 'Dear Colleague' letter for additional guidance.

Child & Visit Information

Last name:	First name:	DOB:	Sex:
Was an interpreter or translation service used in the performance of this assessment? • No • Yes, language used during assessment: _____			
Visit type: • Initial • Follow-up	Location: • In-person • Telehealth	Date evaluated:	Time evaluated (24 hr):

Chief complaint/History of present illness as reported by child and/or care provider staff:

History (Required for Initial Visits Only)

Past psychiatric history, including hospitalizations:

History of self-harm/suicide attempt:

History/Evidence of Abuse: • Denied • Yes, specify: • Verbal/Emotional • Physical • Sexual • Other: _____

Substance use: • Denied • Yes, specify frequency of use and date of last use (DLU) of each substance used:

Substance	Freq of use	DLU	Substance	Freq of use	DLU	Substance	Freq of use	DLU
Alcohol			Ecstasy			Nicotine (e.g., cigarettes, vaping)		
Marijuana			PCP			Inhalants		
Other depressants			Other stimulants			Hallucinogens or Psychedelics (e.g., LSD, mushrooms, mescaline)		
Cocaine			Heroin					
Crack			Other opiates					

Psychiatric medications history: • No • Yes, specify below:

Medication Name & Dose	Indication	Frequency	Date Started	Date Ended

Medical history:

Allergies to medications: • No • Yes, specify medication, reaction, and date of last reaction: _____

Psychiatric Review of Systems (ROS)

Were any mental health symptoms reported by the child?

• No • Yes, specify below:

- | | |
|---|---|
| <ul style="list-style-type: none">• 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 paranoia or delusions• Has trouble eating, sleeping• Has nightmares | <ul style="list-style-type: none">• 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: |
|---|---|

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requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0509 and the expiration date is **XX/XX/XXXX**.
If you have any comments on this collection of information, please contact ORRDHUAC@acf.hhs.gov.

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¹ Referral to a residential treatment center (RTC) requires the recommendation of a licensed psychiatrist (MD/DO) or psychologist (PhD/PsyD).

Mental Status Exam (MSE)		
	Normal	Outside of Normal Limits, Specify:
Mood:	• Euthymic	• Sad • Irritable • Angry • Anxious • Other: _____
Affect	• Reactive & mood congruent	• Restricted • Blunted • Flat • Incongruent • Labile • Other: _____
Attitude	• Cooperative	• Guarded • Defensive • Hostile • Evasive
Behavior	• No psychomotor agitation/retardation; no tremors/tics	• Psychomotor agitation • Psychomotor retardation • Tremors • Tics • Abnormal posturing • Other: _____
Orientation	• Oriented time/place/person/situation	• <u>Not</u> oriented to: • Time • Place • Person • Situation
Concentration / Memory	• Attentive, short- & long-term memory intact	• Inattentive • Distractable • Impaired short-term memory • Impaired long-term memory
Speech	• Normal rate/tone/volume without pressure	• Rapid • Slowed • Loud • Slurred • Other: _____
Thought process	• Goal-directed & logical	• Disorganized • Tangential • Circumstantial • Loose associations • Flight of ideas • Perseveration • Thought blocking • Other: _____
Thought content	• No delusions, hallucinations, active SI or HI	• Delusions • Hallucinations • SI, active • HI, active
Insight/Judgement	• Good • Fair • Poor	

Assessment & Plan

Diagnoses:

ICD-10 Code	Diagnosis, Check if New	Referrals/Follow-up (e.g., Return to Clinic, ER, PHP, RTC ¹ Referral) Check if None/PRN	Timeframe/Date. if applicable
	•		•
	•		•
	•		•
	•		•
	•		•

Plan: All fields required; please specify as indicated.

• No • Yes **Labs/imaging** ordered/performed, specify name:

1. _____ 3. _____

2. _____ 4. _____

• No • Yes **Medications** prescribed, including OTCs:

Medication Name & Dose	Admin Route	Indication	Start Date	Duration	Refills

€ No € Yes **Increased level of supervision** required for mental health risk: _____

• No • Yes **Accommodation** required for a continuous or intermittent physical/mental impairment that is affecting/may affect a **major life activity / bodily function**; specify diagnosis, accommodation (e.g., quiet areas, educational assistance, community-based therapy), & duration (past & anticipated):

Diagnosis	Accommodation	Duration, check if ≥ 6 mos.
		•
		•
		•
		•
		•

• No • Yes **Travel restrictions** (e.g., no travel, mental health escort): _____

Additional Information:

Acknowledgment

I hereby confirm that the information that I have documented on this form is complete and accurate to the best of my ability. Furthermore, I agree to release all of the child's relevant health records to ORR, including but not limited to office notes, treatment plans, and other pertinent documentation, to ensure continuity of care.

Healthcare Provider Signature: _____**Date:** ____ / ____ / ____**Healthcare Provider Printed Name:** _____**Credentials:** _____**Clinic Name:** _____**Phone #:** _____

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