

Date Re-Assessment Started: _____

Assessing Practitioner (Name and Discipline): _____

Date of client's Full Assessment to be used as the baseline for this Re-Assessment: _____

Date of client's most recent Re-Assessment (if applicable): _____

Other Sources for Re-Assessment Information: _____

Purpose: <input type="checkbox"/> Tri-Annual <input type="checkbox"/> Returning to Treatment

Reason for Referral/Chief Complaint

Describe precipitating event(s)/Reason for Referral:

Tri-Annual – same as Full Assessment Returning to Treatment – updates include the following: (describe below)

Current Symptoms and Behaviors (intensity, duration, onset, frequency) and Impairments in Life Functioning caused by the symptoms/behaviors (from perspective of client and others):

Client Strengths (to assist in achieving treatment goals such as athletics, clubs, affiliations, social, personal, relations)

History of Presenting Problem

History of Presenting Problem Prior to Precipitating Event: Include how it is a problem, caregiver perception of cause, relevant factors (environment, relationships, traumatic events, sleep patterns, eating patterns, hygiene changes)

Tri-Annual – same as Full Assessment Returning to Treatment – updates include the following: (describe below)

Additional Problem Areas and Associated Behaviors: Peer Problems and Other Problems

Tri-Annual – same as Full Assessment Returning to Treatment – updates include the following: (describe below)

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

DMH ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

Mental Health History

Psychiatric Hospitalizations: No Updates Updates include the following: (describe below)

Outpatient Treatment:

Suicidal/Homicidal Thoughts/Attempts No Updates Updates include the following: (describe below)

Columbia Suicide Risk Severity Scale Completed? Yes No (For Directly-Operated)

If Columbia Suicide Risk Severity Scale NOT completed, describe below and include dates, threat, intent, plan, target(s), access to lethal means, method used:

Self-Harm (without statement of suicidal intent) No Updates Updates include the following: (describe below)

Trauma or Exposure to Trauma: No Updates Updates include the following: (describe below)

Medications

Medications (Name, dosage, frequency, period taken, effectiveness, response, side-effects, reactions)

See Medication Note dated _____ Updates include the following: (describe below)

Substance Use/Abuse

Substance Use and Abuse

No Updates Updates include the following: (describe below)

(If applicable: Completed COD Assessment dated _____)

Medical History

Medical History

Date of Last Physical Exam: _____

No Updates Updates include the following: (describe below)

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

DMH ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

Developmental Milestones (Describe if not within normal limits)		Environmental Stressors Moves; schools; losses of fam/friends, changes in fam composition; SES, lifestyle; exposure to fam conflict/violence; major illnesses; abuse; placements, etc.
<p>Infancy (0-3) Motor – sit, crawl, walk Speech; Eat; Sleep Toilet training Coordination Temperament Separation</p>	<p><input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)</p>	Infancy (0-3)
<p>Early Years (4-6) Social Adjustment Separation Sexual Behaviors Self-Care</p>	<p><input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)</p>	Early Years (4-6)
<p>Latency (7-11) School adjustment Peer & adult relations/friends Interest/hobbies Impulse control Self-Care</p>	<p><input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)</p>	Latency (7-11)
<p>Adolescence (12-on) Separation/individ. Sexual orientation Sexual behavior Gender identity Relationships/Support Systems Independent funct. Moral development</p>	<p><input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)</p>	Adolescence (12-on)

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

DMH ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

Psychosocial History

School History

Educational Comments: Type of School, Academic Performance, Grade Retention, School Changes, Attitude/Behavior, Attendance/Tuancy, Suspension

No Updates Updates include the following: (describe below)

Vocational Information (jobs, independent living program, training, job related problems, volunteer work, career interests)

No Updates Updates include the following: (describe below)

Juvenile Court History (arrests/offenses, tickets/warnings, probation/stipulations, incarceration, placement)

No Updates Updates include the following: (describe below)

Child Abuse and Protective Services Information (nature of allegations, age of occurrence, offender, dependency court action, child/parent response, placement and type, services)

No Updates Updates include the following: (describe below)

Current Living Situation

Living Situation Type: Biological Adoptive Guardian Foster Kinship/Relative Group Home Other

Others Diagnosed with Mental Illness in Living Situation: Yes No

Significant Current Drug/Alcohol Use in Living Situation: Yes No

Family Composition (Include siblings, stepparents/others, grandparents, extended family, ethnicity/culture, education, socio-economic, religious affiliation)

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

DMH ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

Mental Status

Provide a word picture of this child based on your observations.
Be sure to address relevant features from each **bolded** category in the left column.

- Appearance**
Dress, grooming, unusual physical characteristics

- Behavior**
Activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

- Expressive Speech**
Fluency, pressure, impediment, volume

- Thought Content**
Fears, worries, preoccupations, obsessions, delusions, hallucinations

- Thought Process**
Attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g. planning)

- Cognition**
Orientation, vocabulary, abstraction, intelligence

- Mood/Affect**
Depression, agitation, anxiety, hostility absent or unvarying, irritability

- Suicidality/Homicidality**
Thoughts, behavior, stated intent, risks to self or others, access to lethal means

- Attitude/Insight/Strengths**
Adaptive capacity, strengths & assets, cooperation, insight, judgment, motivation for treatment.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____ **DMH ID#:** _____
Agency: _____ **Provider #:** _____

Los Angeles County – Department of Mental Health

Summary and Diagnosis

I. Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)

II. Diagnostic Descriptor

ICD Diagnosis Code (check at least one Primary)

Primary Code _____
 Sec Code _____
Code _____
Code _____
Code _____
Code _____
Code _____
Code _____
Code _____

III. Specialty Mental Health Services Medical Necessity Criteria:

- 1. Medi-Cal Specialty Mental Health Included Diagnosis Yes No
- 2. Significant impairment in life functioning due to the Included Diagnosis Yes No
- 3. Expectation that proposed interventions can impact the client's condition Yes No
- 4. Condition will not be responsive to physical health care based treatment Yes No

IV. Disposition/Recommendations/Plan

V. Signatures

Assessor's Signature & Discipline Date Co-Signature & Discipline Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____ DMH ID#: _____
Agency: _____ Provider #: _____

Los Angeles County – Department of Mental Health