CFS 431-2
8/2011

State of Illinois
Department of Children and Family Services

Outpatient Psychiatry Request Form

Criteria: DCFS youth in care with mental health problems that are causing significant distress or functional impairment in their family, school or other environment. Please complete all sections of this form. You will receive a call from a Consulting Psychologist to review the information and to make the appropriate referral.

Youth in Care Information			
Date	Child's Name		DCFS ID#
☐ Male ☐ Female	Date of Birth	Race	
Language(s) spoken at home?		Interpreter Needed? ☐ Yes ☐ No	
Placement: ☐ Foster Care ☐ Spec Foster Care ☐ Relative Foster Care ☐ Relative Spec Foster Care ☐ Intact ☐ Returned Home of Parent ☐ Sub-guardianship ☐Adoption ☐ Group Home ☐ Residential Treatment Facility ☐ TLP ☐ ILO ☐ Other _____			
☐ Psychiatric Hospital (if hospitalized, also check prior placement type above)			
Care Giver Information			
Name	Phone #		
Address	City	Zip Code	
☐ COOK REGION (Check area below)			
☐ South City ☐ Central City ☐ North City ☐ South Suburban ☐ West Suburban ☐ North Suburban			
☐ NORTHERN REGION ☐ CENTRAL REGION ☐ SOUTHERN REGION			
Case Worker Information			
Name	Phone #		
☐ OUTLOOK or Email:	Fax #		
☐ DCFS Office / ☐ POS Agency:			
Address	City	Zip	
Supervisor	Region/Site/Field		
Reason for Referral			
☐ Medication Consultation/Review ☐ Diagnostic Clarification ☐ Medication Management/Treatment			
Presenting Problem(s) including symptoms, behaviors, duration, severity, history and any complicating factors:			
Clinical Features/Mental Health Concerns			
Current DSM Diagnosis(es):			
DESCRIBE ANY CURRENT SAFETY ISSUES such as danger to self or others, psychotic symptoms, violent behaviors:			
Current Concerns:			
☐ Adjustment to Trauma ☐ Anger Management Issues ☐ Aggressive Behavior - Verbal ☐ Aggressive Behavior - Physical ☐ Anxiety ☐ Damaging Property ☐ Decreased Energy	☐ Depression ☐ Hallucinations ☐ Hopelessness/ Helplessness ☐ Hyperactivity ☐ Impulsivity ☐ Insight/Judgment Problem ☐ Oppositional/Defiant	☐ Poor Concentration ☐ Re-experiencing ☐ Severe Mood Swings ☐ Sleep Disturbance ☐ Somatic Complaints ☐ Traumatic Grief/Separation ☐ Other? _____	

Child's Name			DCFS ID#
CURRENT MENTAL HEALTH TREATMENT			
Outpatient **psychiatrist** currently seeing or ☐ check if NONE			
Name		Date started	Estimated # Visits
Reason for Visit			
Address		City/Zip	Phone

Current Medication(s)	Dose	Frequency	Additional Information:

Progress in Treatment: ☐ Improved ☐ Little or No Progress ☐ Regressed due to stressor ☐ Near Completion

List outpatient **psychologist/therapist** currently seeing or ☐ check if NONE

Name (with credentials)	Date started	Estimated # Visits

Reason for Visit		
Address	City/Zip	Phone

Progress in Treatment: ☐ Improved ☐ Little or No Progress ☐ Regressed due to stressor ☐ Near Completion

Alcohol/Substance Use?

☐ None ☐ Yes, indicate type, frequency, duration

HISTORY OF MENTAL HEALTH TREATMENT or ☐ check if NONE

Any Medication(s), psychiatrists, outpatient therapists within past two years that is not listed above:

Inpatient Treatment or ☐ check if NONE

Total Number of Inpatient Psychiatric Hospitalizations: ☐ 1 – 3 ☐ 4 – 6 ☐ 7 – 9 ☐ >10

Exposure to Trauma History If YES, describe

☐ Yes	☐ No	Sexual Abuse	☐ Yes	☐ No	Domestic Violence
☐ Yes	☐ No	Physical Abuse	☐ Yes	☐ No	Victim Criminal Activity
☐ Yes	☐ No	Emotional Abuse	☐ Yes	☐ No	Parental/Family Criminal Activity
☐ Yes	☐ No	Child Neglect	☐ Yes	☐ No	Community/School Violence
☐ Yes	☐ No	Medical Trauma	☐ Yes	☐ No	Natural or Manmade Disaster

Describe Trauma History:

REFERRAL from (check all that apply) ☐ Caseworker ☐ Caregiver ☐ Pediatrician ☐ Therapist ☐ School
☐ Integrated Assessment ☐ Integrated Assessment with Screener ☐ CAYIT Staffing ☐ Help Unit
☐ Family Team Meeting ☐ Clinical Staffing ☐ Psychological Evaluation ☐ Court Order ☐ Court Request

DO NOT WRITE ON THIS PAGE – FOR CONSULTING PSYCHOLOGY USE ONLY
This form will be returned to the referring caseworker with the information below completed.

CONTACTS:

☐ Phone	☐ Email	Date:	☐ Phone	☐ Email	Date:
☐ Phone	☐ Email	Date:	☐ Phone	☐ Email	Date:
☐ Phone	☐ Email	Date:	☐ Phone	☐ Email	Date:

RESPONSE:

☐ Accepted for Referral	Referral Clinic:	Location:

Please take this entire form to the first appointment.

☐ Unable to Contact (attempts listed above)

☐ Information reviewed and available services do not meet the needs of the child; Recommendations:

☐ Patient Declined Service; Reason:

Expiration Date: Referral duration is **6 Months**; after that a new form needs to be submitted

Consultant:	Date:	Consult Review #