CFS 968-90
Rev 9/2022

Date:
To:
Subject: Client Information Concerning:

Household Members	Relationship to Client	Age

Dear Mental Health Professional:

Your client ________________________________ has been referred to the Department of Children and Family Services. The family came to the attention of the Department regarding (summarize reason for involvement):

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Your client is the parent or caregiver to a subject of a DCFS report and has identified you as a mental health services provider. Attached is the signed consent for release of information. Your answers to the attached questions will support us in our commitment to ensure the safety of the children and effectively serve the family. **Please attach a copy of the most recent Mental Health Assessment, Psychiatric Evaluation, Psychological Evaluation, and Treatment Plan.**

Respectfully,

DCFS worker or investigator/Community Provider worker name:
Agency:
Address:
Supervisor:
Telephone:
Cell Phone:
Facsimile:

Questions for Mental Health Professionals

Client's Name:
DOB:

I. Referral Information:

a. Client was referred to you by:

b. Date of Intake:

c. Type of Service:

d. Date of First Session:

Were any of the following tests, assessments, or evaluations completed for the client?

1. **Mental Health:** ☐ Yes ☐ No If yes, date of most recent session? Please attach the most recent progress note.

2. **Psychiatric:** ☐ Yes ☐ No If yes, date of the evaluation? Please attach the written report or name/contact of the provider who completed the evaluation.

3. **Psychological:** ☐ Yes ☐ No If yes, date of the evaluation? Please attach the written report or name/contact of the provider who completed the evaluation.

4. **Neuropsychological:** ☐ Yes ☐ No If yes, date of the evaluation? Please attach the written report or name/contact of the provider who completed the evaluation.

5. **Parenting Capacity:** ☐ Yes ☐ No If yes, date of the evaluation? Please attach the written report or name/contact of the provider who completed the evaluation.

II. Mental Health Diagnosis:

Diagnosis (ICD-10-CM):

III. Medication:

A. What are the current medications? If none, please indicate.

Medication	Dosage	Reason for Medication

B. Is the client adherent with medication? ☐ Yes ☐ No

C. Without the medication, are you concerned about a risk of harm to the child(ren) while the client is in a caregiver role and if so, why?

Questions for Mental Health Professionals

D. What treatments or interventions do you recommend to promote the safety and well-being of your client's child(ren)?

E. Is your client receiving these treatments or interventions?

F. Is your client adhering to/participating in these treatments or interventions?

IV. Treatment or Intervention Plan:

A. Date plan was created:

B. Last date plan was evaluated and reviewed with client:

C. Describe the client's insight regarding his/her behavioral health needs:

D. Utilizing the rating scale below, what is the overall rating regarding the client's attendance, engagement, and participation? Please explain the reason for your rating including your observations of the client to support your rating:

1________2________3________4________5________6________7________8________9________10

1 = Very bad could not be worse
2= Markedly Worse
3= Moderately Worse
4= A Little Worse
5= Unchanged
6= A Little Improved
7= Moderately Improved
8= Markedly Improved
9= Major Improvement
10= Normal Functioning

V. Additional Questions:

1. What is the frequency of contact with the client?

2. Have you met the client's children?
   If yes, please provide any insight to the child(ren)'s behavior, well-being, interactions with client, etc.

3. Do you speak with members of the client's support system?
   If yes, please provide insight into the positive vs negative influences of the client's social circle/support.

VI. Acknowledgements:

Name of person providing mental health treatment:

Credentials/Licensure:

Printed name of person completing this request:

Signature:____ Date:____________________