(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

Information for Admission to Child Diagnostic Unit

Date:________________________

Patient Name:____ SS#________________________

Address:____ County:________________________

City:______________________________________State:___________Zip:_______________________

DOB:______________________________ Age:_______________Race:________________________

Gender: ___________ Preferred Gender: ____________Height:__________Weight:_____________

Patient's Medicaid #:_____________________________

Other Insurance:_______________________ Group #:_____________________ Policy #____________

Person filling out Application Packet: ____

Relationship to patient: ____

Parent/Guardian:____SS#_________________________

Parent/Guardian:____SS#_________________________

Address:____

City:______________________________________State:____________Zip:________________________

Phone #:______________________________________ Phone #:_________________________________

Parent/Guardian DOB:___________________________ Email Address:___________________________

Who referred patient to CDU?____

Outpatient Psychiatrist and Clinic: ____

Outpatient Therapist: __________________________Outpatient Therapist #_______________________

PCP:______________________________ PCP#:______________________PCP Fax #_________________

Complaint: Behavioral Problems
Room: PI 5 5s Estimated LOS: 28 Days

Psychosocial Assessment

What problems has the child been having?

____
____
____
____
____
____

Are you seeking admission due to a current court order? [ ] yes [ ] no

What are your goals for admission?

____
____
____
____

Child's Mental Health History

Any previous Psychological Testing? ____________________ If so when? ____
By whom? ____
Past Psychiatric Diagnoses: ____
____

Child's Mental Health Symptoms:

[ ] history of suicide attempt
[ ] history of threatening suicide
[ ] agitation
[ ] feelings of hopelessness
[ ] recent family/ friend loss
[ ] disruption of support system*
[ ] cruelty to animals
[ ] thoughts of harming others
[ ] poor sleep patterns
[ ] sexually acting out*
[ ] delusions/hallucinations
[ ] hyperactivity
[ ] depression
[ ] weight gain/ loss
[ ] self-injury
[ ] disorganized speech
[ ] catatonic behavior
[ ] panic attack
[ ] trauma*
[ ] physical aggression*
[ ] property destruction*
[ ] fire setting
[ ] death in the family
[ ] anxiety
[ ] paranoia

Please explain any starred (*) items: ____
____
____
____
____
____

Prior **Outpatient** Treatment: (Including school-based and day treatment)

Facility	Start	End	Reason for Treatment	Therapist Name, Phone Number

Chief Complaint: Behavioral Problems
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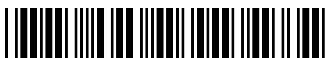

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Prior **Inpatient** Treatment: (Including acute or residential care)

Facility	Start	End	Reason for Admission

What is the child's current living situation? ____

____

Child's Legal Parent:____

Child's Legal Parent:____

Have parental rights been terminated from either parent? Mother: [ ] yes [ ] no Father: [ ] yes [ ] no

If you are not the child's parent, describe your relationship to the child: ____

____

Custodians or guardians must provide documentation to verify authority to act on behalf of the patient and agree to inform UAMS PRI of any changes in status during the course of treatment.

I, ____________________________________, confirm that I am the [ ] biological parent, [ ] custodian, [ ] adoptive parent, [ ] or other legal guardian of _________________________________, and I have legal authority to consent to his/her admission at UAMS Psychiatric Research Institute.

____ ___________________ _________________

Signature of Parent/Custodian/Guardian Date Time

Please list all of the individuals living in the primary home setting:

Name: ____________________________________Relationship:__________________________Age: ________

Name: ____________________________________Relationship:__________________________Age: ________

Name: ____________________________________Relationship:__________________________Age: ________

Name: ____________________________________Relationship:__________________________Age: ________

Name: ____________________________________Relationship:__________________________Age: ________

Name: ____________________________________Relationship:__________________________Age: ________

Name: ____________________________________Relationship:__________________________Age: ________

Name: ____________________________________Relationship:__________________________Age: ________

Describe any special custody/ visitation issues that we need to consider during the child's stay, such as court ordered visitation, limited phone calls, orders of protection, no contact orders, etc.: ____________________________________

____

____

Does anyone close to the child have legal limitations from interacting with other children? [ ]yes [ ]no

Where does the child typically sleep? ____

With whom do they share a room? ____

With whom do they share a bed? ____

Has the child used drugs or alcohol? [ ] yes [ ] no [ ] unknown

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Family Environment:

[ ] divorce/ separation [ ] recent death [ ] recent birth [ ] family violence
[ ] family member illness [ ] unemployment [ ] gang activity [ ] financial problems
[ ] multiple moves [ ] family incarceration [ ] family member with substance abuse
Other: ________________________

Academic Information:

School:____Grade:____________________________
Teacher: _________________________________ Teacher's #: _____________________________________
Teacher Email: ____________________________
Current Classroom Type: [ ] Regular [ ] Self-contained [ ] Resource [ ] ALE [ ] Day Treatment
Past classroom settings: [ ] Self-contained [ ] Resource [ ] ALE [ ] Day Treatment
Current Academic Performance/ Grades: [ ] A's [ ]B's [ ]C's [ ]D's [ ]F's [ ] not applicable
Does the child have a(n): [ ] IEP [ ] 504 (Please provide a copy)
Has the child repeated a grade? [ ] yes [ ] no Which grade?_____________________________________
Does the child have a personal aide at school? [ ] yes [ ] no [ ] part of the day: _________________________
Does the child have friends at school? [ ] yes [ ] no ____
Extra- Curricular activities: ____
Check problematic behaviors in school:

[ ] tardy often [ ] aggression [ ] repeated grade
[ ] disruptive [ ] skipping classes [ ] poor performance
[ ] problems with peers [ ] defiance [ ] suspended/ expelled
[ ] meltdowns [ ] work refusal [ ] problems on the school bus
[ ] difficulties with transition [ ] won't stay seated [ ] talks excessively
Other:____

Legal History:

Does the child have a FINS petition? [ ] yes [ ] no If yes, provide a copy.
What is the name and contact information of the FINS officer? ________________________________
Has the child ever been in the custody of DHS or Social Services? [ ] yes [ ] no
Reason for custody placement: ____
Estimated dates in DCFS custody? ____
If currently in DCFS custody, can child return to current placement? [ ] yes [ ] no
If no, has placement been identified? [ ] yes [ ] no Where: _____________________________
Name of Caseworker: _______________________ Phone: ________________________________

Child's Medical History

Medical problems: ____
Allergies (Food, drug, environmental):____
Please check if the child has a history of any of the following:

[ ] Premature birth _____ weeks [ ] Lice: last treatment ___________
[ ] Multiple ear infections [ ] Flu in the last year [ ] Constipation
[ ] Severe Strep throat [ ] Feeding difficulties [ ] Seizures
[ ] Broken Bones [ ] Severe injury [ ] Severe head injury
[ ] Prenatal drug or alcohol exposure [ ] Multiple medical hospitalizations

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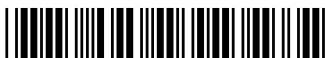

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List of Current Medications:

Medication: ____Dose: _____________________________
Medication: ____Dose: _____________________________
Medication: ____Dose: _____________________________
Medication: ____Dose: _____________________________
Medication: ____Dose: _____________________________
Medication: ____Dose: _____________________________

Special Needs:

Does the child have trouble seeing or wear glasses? ____
If the child wears glasses, do they have difficultly seeing distance or reading? ______________________
Does the child have trouble hearing or wear a hearing aid?_____________________________________
Does the child have trouble speaking or use a communication device?____________________________
List any concerns you have about the child's hearing, vision or speaking: ____
____

*Please bring glasses, hearing aids or other devices the child uses.
Does the child speak English?__________ What other languages are spoken in the home?___________________

Has the child ever received:

Speech Therapy? [ ] yes [ ] no Currently Receiving [ ] Previously Received [ ]
Location: __________________________Estimated Dates: ______________________________
Physical Therapy? [ ] yes [ ] no Currently Receiving [ ] Previously Received [ ]
Location: __________________________Estimated Dates: ______________________________
Occupational Therapy? [ ] yes [ ] no Currently Receiving [ ] Previously Received [ ]
Location: __________________________Estimated Dates: ______________________________

Does the child have any sensory issues (such as limited food eaten, bothered by clothing tags or seams, dislikes haircuts, dislikes loud noises or bright lights, etc.)?____
____
Does the child have difficulty with motor coordination (buttons, zippers, tying shoes, riding a bike, poor handwriting)?
____
____

Check if the child can do the following:

[ ] Dress self [ ] Toilet self [ ] Bathe self [ ] Feed self

Does the child wear diapers? [ ] yes [ ] no If yes, when? [ ] Day [ ] Night
Does your child have frequent accidents with [ ] urine and/or [ ] feces? [ ] yes or [ ] no
Do accidents occur [ ] daily or [ ] on occasion?
Is there any other information that we need to know about the patient?
____
____
____
____

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