(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

(Place MR Label Here)
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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
Room: PI 5 5s Estimated LOS: 28 Days

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

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

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

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

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

Chief Complaint: Behavioral Problems
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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?
____
____
____
____

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

CHILD DIAGNOSTIC UNIT BEHAVIORAL CHECKLIST

Client's Name: DOB:

Guardians Name:

Name of Person Completing Form:
☐ Parent ☐ Guardian ☐ Foster Parent ☐ DCFS ☐ Therapist ☐ Other

Address:

Phone Number: Email Address:

Medicaid Number: PASSE: PASSE Number:

Please Circle Appropriate Boxes

Physical Aggression	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Hits Kicks Bites Shoves Trips Pushes Other						
Verbal Aggression	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Curses Yells Demands						
Fire Setting	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Plays with matches Hides lighters Caught item on fire						
Enuresis/Encopresis	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Daytime Nighttime Wears Pull-Ups						
Homicidal Ideation/Attempt	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Threatens others Physically hurts others Plans to hurt someone						
Activities of Daily Living	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Unable to bathe Unable to get dressed Unable to toilet Unable to feed self						
Self Injurious Behaviors	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Cuts self Head bangs Pulls Hair Hits self Scratches self Picks sores Burns self						
Problematic Sexual Behaviors	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Makes comments Makes gestures Touches self Touches others Exposes self Charged files						
Suicidal Ideation/Attempt	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Thinks of death Draws pictures of death Cutting Strangulation/Choking Poison						
Anxiety and Panic	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Fidgets Worries Social or performance situations Separating from family Dark Storms Watchful						
Phobias	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Please List Specific fears:						
Nutrition Concerns	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Overeats Throws up Poor Appetite Hoards Foods Picky Eater						
Mood	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Sad Hopeless Worthless Isolative Irritable Angry Mood swings						
Impulsive Behavior	NONE	DAILY	WEEKLY	MONTHLY	SCHOOL	HOME
Climbs objects Tears things apart Acts without thinking No cause and effect						

Problems with Truth Telling	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Doesn't tell the truth exaggerates negative lies to avoid getting in trouble						
Oppositional	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Refuses directions Lies about completing items Talks back or argues Disregards typical schedules/rules						
Property Destruction	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Holes in walls Tears toys up Defaces school property Defaced vehicle						
Destroys others Property	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Electronics Furniture Toys Sentimental Objects						
Running Away	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Several hours Overnight						
Social Withdrawal	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Refuses activities No friends Avoids social situations Avoids Public Places						
Stealing	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Takes things Hides things Never asks permission Steals from stores Steals from school						
Decreased Concentration	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Unable to focus Zones out Day dreams Distractible						
Hyperactivity	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Always moving Unable to sit still Clumsy Often gets items wrong at school						
Distractible	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Messy Unorganized Forgetful Never on task Watches other/things Poor Focus						
Paranoia	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Thinks others are out to harm him No one's on their side World is a bad place						
Animal Cruelty	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Accidentally hurt animal Purposefully hurt animal Accidentally killed an animal Purposefully killed animal						
Rituals or Compulsions	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Please explain:						
Inflexible/Rigid	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Poor with schedule change Unable to see other's perspectives Stuck on routine						
Sensory Concerns	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Loud noises Crowds Textures/Food Clothing						
Thought Disorder	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Hears things Sees Things Feels things						
Alcohol/Tobacco/Drug Use	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**
Please Specify:						
Hypersomnia/Insomnia	**NONE**	**DAILY**	**WEEKLY**	**MONTHLY**	**SCHOOL**	**HOME**

Day time naps   Trouble going to sleep   Trouble staying asleep   Early riser   Bad dreams   Sleep walks

Please describe any other behavior (giving dates, frequency, and severity):

Family Involvement

Do you plan to visit: Never   Daily   Weekly

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

CDU Authorization for Release of Information

I, ______________________________, whose relationship to the patient is ________________________, authorize the PRI Child Diagnostic Unit to:

[ ]Release information to: [ ] Obtain information from:

____
(Agency/Individual)
____
(Address)
____

____
(Phone)

Pupose of Access or Release:
[ ] continuity of care
[ ] coordinate services
[ ] school
[ ] medical
[ ] reimbursement
[ ] patient request
[ ] other: ______________
____

Information of (patient name): ________________________________ Birthdate &/or SSN#: ________________

The specific information to be requested or released:
[ ] Discharge/Treatment Summary [ ] Psychiatric/Medical Evaluation [ ] Dates of Treatment [ ] Diagnostic Evaluation
[ ] Lab/Other Diagnostic Records [ ] Social History [ ] Medical/Physical History [ ] Progress Notes
[ ] Treatment Plans [ ] School Observations [ ] Medication History [ ] Speech and Language Evaluation
[ ] Psychological Evaluation /Testing [ ] Occupational Therapy Evaluation [ ] Verbal Progress Reports
[ ] Patient Demographics/ Insurance information [ ] Other: ____

A photocopy or faxed copy of this signed authorization shall constitute a valid authorization. I certify that this authorization has been given voluntarily and without coercion. I understand that I may revoke this authorization at any time by giving written notice, except to the extent that action has been by the CDU in reliance upon this authorization. I understand that the CDU Program will not condition treatment, payment, enrollment or eligibility for treatment on my signing of this authorization.

The PRI CDU Program, its faculty and staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

This authorization will automatically expire 90 days after the date of the signature or 90 days after the termination of treatment, whichever is later, unless I give written notice that I revoke the authorization effective upon an earlier date. I agree that all blanks in this form are properly filled in prior to my signature.

I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by federal privacy laws and regulations. I authorize the release of information between CDU & Psych TLC Staff and teachers, principals and other school officials as needed for the treatment program.

I understand that the UAMS may charge a reasonable, cost-based fee for copies of medical records that includes the cost of copying, cost of supplies, labor of copying, and postage, if applicable. UAMS will not charge more than is allowed by law.

I represent that I am authorized by law to act on behalf of the patient identified above.

____ ________________
Signature of parent/ guardian/legal representative Date/Time

____ ________________
Signature of witness Date/Time

____ ________________
Signature of client (if applicable) Date/Time

____ ________________
Signature of 2nd witness (when verbal consent is obtained) Date/Time

PROVIDE COPY TO PATIENT/LEGAL REPRESENTATIVE

HIPAA UAMS Administrative Guide Policy #3.1.28 Use and Disclosure of PHI and Medical Records Policy