

Mental Health Assessment Form Unaccompanied Alien Children Bureau Office of Refugee Resettlement (ORR)

General Information

Child	Last name:		First name:			
	DOB:	A#:	Sex:	Date evaluated:	Time evaluated:	
	Primary language:		Who provided appropriate language services for child during evaluation?	• HCP fluent in child's primary language	• Trained interpreter	• Not provided
Evaluating Healthcare Provider (HCP)	Name: MD / DO / PA / NP / PhD / PsyD		Phone number:		Clinic or Practice:	
	Street address:			City/Town:		State:
	Location where child received care (e.g., Psychiatrist/Psychiatric NP or PA visit, Psychologist visit):					
Program	Program name:			• Program Staff Member Present During Exam with HCP		

Reason for visit: • Initial specialist visit • Follow-up specialist visit

History and Assessment

Vital Signs

Temperature (T)	Heart Rate (HR)	BP (≥ 3 yrs)	Resp Rate (RR)	Height (HT)	Weight (WT)	BMI (≥2 yrs)	BMI %ile
°C				cm	kg		

Allergies: € No € Yes, specify below:

	Food	Medication	Environmental
Allergen			
Reaction			

Medical & Mental Health History (including dates & locations of care):

Surgeries: _____
 Hospitalizations: _____
 Chronic/Underlying conditions: _____
 Family history: _____

Medications, (dosage frequency & dates): • Past: _____
 • Current: _____

Reproductive history (complete for anatomically female UC who have started menarche):

Date of LMP: ___/___/___, • Approximate • Exact • Contraceptive use, specify: _____ • Currently breastfeeding

Abuse: • Yes, specify • Denied, with no obvious signs • Denied, but obvious signs present • Unknown

- Verbal:
- Emotional:
- Physical:
- Sexual:
- Other victimization (e.g., gang, bullying, crime):

Substance use: • Yes, specify • Denied, with no obvious signs/symptoms • Denied, but obvious signs/symptoms present • Unknown

	Alcohol	Tobacco / Nicotine	Marijuana	Injection drugs	Other substances
Specify substance(s)			N/A		
Frequency/Quantity					
Date of last use					

Review of Systems (ROS) and Mental Status Exam (MSE)

Were any mental health signs/symptoms reported by the child or observed by program staff or HCP? • No • Yes, specify below:

- | | |
|---|---|
| <ul style="list-style-type: none"> • Feels empty, hopeless, sad, numb more often than not • Feels constantly worried, anxious, nervous more often than not • Has trouble concentrating, restless, too many thoughts • Experiences mood swings, from very high to very low • Hears voices or sees things others do not see (hallucinations) • Has trouble eating, sleeping • Has nightmares | <ul style="list-style-type: none"> • Engages in self-harm • Feels easily annoyed or irritated • Relives traumatic events from the past • Feels afraid, easily startled, jumpy • Thoughts of hurting self, would be better dead • Thoughts of hurting others |
|---|---|

Can child attribute feelings to a specific reason(s)? • No • Yes, specify: _____

Brief Mental Status Exam (MSE)

	Normal	Abnormal, specify:
Appearance	• Normal grooming & hygiene	•
Attitude	• Calm & cooperative	•
Behavior	• No unusual movements or psychomotor changes	•
Speech	• Normal rate/tone/volume without pressure	•
Affect	• Reactive & mood congruent; good range	•
Mood	• Euthymic	•
Thought processes	• Goal-directed & logical	•
Thought content	• Not passive/active suicidal/homicidal	•
Perception	• No hallucinations or delusions during interview	•
Orientation	• Oriented time/place/person/ self	•
Memory/ Concentration	• Short and long term intact	•
Insight/Judgement	• Good • Fair • Poor	

Diagnosis and Plan

Diagnosis: Child with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: • No • Yes
 If **Yes**, check all diagnoses that apply. Specify in the space provided, where indicated.

- DSM:**
- Acute stress disorder/PTSD
 - ADHD
 - Adjustment disorder
 - Autism
 - Bipolar disorder
 - Conduct disorder
 - Eating disorder
 - Generalized anxiety disorder
 - Major depressive disorder
 - Oppositional defiant disorder
 - Panic disorder
 - Primary psychotic disorder
 - Other: _____

Medical: _____

Plan: Check all that apply and specify where indicated. **Please provide copies of office notes and lab/imaging results to program staff.**

- € Age-appropriate anticipatory guidance discussed and/or handout given
- € Child educated on healthcare services received and treatment recommendations
- € Labs/imaging ordered/performed
- € Medications administered/prescribed:

Medication Name	Reason	Date Started	Expected end date	Dose	Directions	Psychotropic
						• No • Yes
						• No • Yes
						• No • Yes

- € Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency:
 - € Onsite care provider clinician evaluation: _____
 - € Increased level of supervision for mental health concern: _____
 - € Placement at a residential treatment center (RTC)¹: _____
 - € Assistance with daily living activities: _____
 - € Other: _____
- € Child has/may have an ADA disability: _____
- Child has health concerns that require follow-up services; specify needs and time frame by when services should occur:
 - Return clinic: _____
 - Mental health specialist evaluation: _____
 - Other, specify: _____

Child cleared to travel:

- Yes, with no restrictions
- Yes, with restrictions (e.g., ground travel, travel safety plan): _____
- No, reason: _____

Recommendations from Healthcare Provider / Additional Information

¹ Requires the recommendation of a psychiatrist or clinical psychologist

Recommendations from Healthcare Provider / Additional Information

Healthcare Provider Signature: _____ **Date:** ____ / ____ / ____

Healthcare Provider Printed Name: _____

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