Psychiatric Report

To be completed by the Psychiatrist at every appointment

ATTENTION Psychiatric Offices:
Please fax completed form to Family Link: 512-233-6473 Ph: 512-233-6464

Name of Child: __________________ **DOB:** _____________ **Date of Visit**:_________________________

☐ Initial Psychiatric Evaluation ☐ Follow up Psychiatric Evaluation

Targeted symptoms, behaviors, concerns: ____

Primary Diagnosis: ____

Current Medication:____

Is this a psychotropic medication for behavioral adjustments? ☐ Yes ☐ No

Is the medication PRN? ☐ Yes ☐ No

Were the possible side effects discussed with patient/ foster parent? ☐ Yes ☐ No

Medication Change? ☐ Yes ☐ No Specify: ____

Discontinuing Medication? ☐ Yes ☐ No Specify: ____

Does the patient have suicidal ideation? ☐ Yes ☐ No

Does the patient have homicidal ideation? ☐ Yes ☐ No

MINI MENTAL STATUS EXAM: (circle one for each area)

Appearance	disheveled	unkempt	neat	well groomed
Affect	labile	restricted	flat	appropriate
Mood	happy	depressed	elated	anxious
General Behavior	combative	calm	rigid	cooperative
Attitude Toward Examiner	hostile	defensive	cooperative	seductive

Suggested Level of Care: ☐ Basic ☐ Moderate ☐ Specialized

Follow up needed? ☐ Yes ☐ No

Date of scheduled follow up appointment______________**(required within 90 days)**

Psychiatrist: printed name: ___________________________ **Signature:** __________________________

Phone Number: ______________________________ **Fax Number:** ______________________________

Address: ____