

- |            |                      |                           |                   |                        |                             |                 |
|------------|----------------------|---------------------------|-------------------|------------------------|-----------------------------|-----------------|
| 1 - Office | 4 - Home             | 8 - Correctional Facility | 11 - Faith-based  | 14 - Client's Job Site | 17 - Non-Traditional        | 20 - Telehealth |
| 2 - Field  | 5 - School           | 9 - Inpatient             | 12 - Health Care  | 15 - Adult Residential | 18 - Other                  | 21 - Unknown    |
| 3 - Phone  | 6 - Satellite Clinic | 10 - Homeless             | 13 - Age-Specific | 16 - Mobile Service    | 19 - Children's Residential |                 |

DATE: \_\_\_\_\_ BILLING TIME: \_\_\_\_\_ LOCATION: \_\_\_\_\_ SERVICE TYPE: **MEDS VISIT**

ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE"). THE ASSESSMENT SHOULD ILLUSTRATE ALL MEDICAL NECESSITY PRESENT AND PROVIDE THE BASIS FOR THE ICD-10-CM DIAGNOSIS.

**IDENTIFYING DATA [JV-220(A) #1 – 5 & JV-220(B) #1 – 4]**

Age: \_\_\_\_\_ yrs. & \_\_\_\_\_: mos. Gender:  M  F Ethnicity: \_\_\_\_\_  
 Brought By (name, role): \_\_\_\_\_  Fa  Mo  Fos. -Mo  Fos.-Fa  Guardian  Other \_\_\_\_\_  
 Minor is Under Jurisdiction of:  CFS  Probation  Other \_\_\_\_\_  N/A  
 Referral Source:  Person(s) child is living with  School  CFS  Probation  Self  Other \_\_\_\_\_  
 Information about the child was provided by [JV-220(A) #6; JV-220(B) #5]:  Child  Caregiver  Teacher  Social  
 Service Practitioner  Probation Officer  Parent  Public Health Nurse  Tribe (specify): \_\_\_\_\_  
 Other (specify): \_\_\_\_\_  Records (specify): \_\_\_\_\_  
 Lives In/With: \_\_\_\_\_  
 Chief Complaint: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current symptoms not alleviated or ameliorated by other current or past treatment efforts [JV-220(A) #12]:  Same as chief complaint  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

History of present illness (including symptoms and duration of symptoms) [JV-220(A) #8 – without tx plan; JV-220(A) #9 & 12; JV-220(B) #7]: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Nonpharmacological treatment alternatives to address concerns provided in the last six months? [JV-220(A) #10; JV-220(B) #8]

Unknown  None provided because \_\_\_\_\_  
 Other: (Describe treatment and the child's response): \_\_\_\_\_  
 \_\_\_\_\_

Pharmacological treatment alternatives tried in the last six months? [JV-220(A) #11; JV-220(B) #7]  Yes  No  Unknown

None provided because \_\_\_\_\_  
 Other: (Describe treatment and the child's response): \_\_\_\_\_  
 \_\_\_\_\_

[JV-220(A) #24] List all psychotropic medications currently administered that will be stopped if this application is granted: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CHILD/ADOLESCENT PSYCHIATRIC EVALUATION AND UPDATE**  
**San Bernardino County**  
**DEPARTMENT OF BEHAVIORAL HEALTH**  
**Confidential Information**  
**See W&I Code 5328**

**NAME:** \_\_\_\_\_  
**CHART NO:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_  
**PROGRAM:** \_\_\_\_\_

**PSYCHIATRIC HISTORY**

Hospitalizations: \_\_\_\_\_

Counseling prior to six months ago: \_\_\_\_\_

**Past Medications [JV-220(A) #11c]**

N/A – No past medications attempted

<u>Medication</u>	<u>Reason for Stopping</u>

**Current Medications [JV-220(A) #9; JV-220(B) #7]**

N/A – No current medications

<u>Medication</u>	<u>Response to Medication</u>

Suicidal/Homicidal Ideas/Self-Injurious Behavior/Aggressive Behavior: \_\_\_\_\_

Physical/Sexual Abuse: \_\_\_\_\_

Legal Problems/Gang Activity/Juvenile Hall/AWOL Behavior: \_\_\_\_\_

Substance Abuse:  Denies  Alcohol  Amphetamines  Benzodiazepines  Cocaine  Inhalants  
 IVDA  LSD  Marijuana  Narcotics  PCP  Other: \_\_\_\_\_

**MEDICAL HISTORY [Include items with \* on JV-220(A) #15; JV-220(B) #10]**

\* Illnesses/Seizures/Allergies:  None  NKA  Other: \_\_\_\_\_

\* Accidents/Head Trauma:  None  Other: \_\_\_\_\_

\* Surgeries:  None  Other: \_\_\_\_\_

\* Hospitalizations:  None  Other: \_\_\_\_\_

\* Current Non-psychotropic Medications:  None  Other: \_\_\_\_\_

\* Last M.D. Visit: \_\_\_\_\_ \* Lab Tests:  Normal  Abnormal \_\_\_\_\_ Pri. Care M.D.: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ [JV-220(A) #1] BMI: \_\_\_\_\_

BMI-for-age Percentile:  Underweight (<5%)  Healthy (5% to 85%)  Overweight (85%-95%)  Obese (>95%)

Menarche  N/A \_\_\_\_\_ LNMP \_\_\_\_\_

Sexual Activity:  Yes  No Last encounter: \_\_\_\_\_

**FAMILY HISTORY**

psychosis  bipolar illness  other mood d/o  drug/alcohol abuse  suicide attempt(s)  suicide(s)  ADHD  
 tics  legal problems  incarcerated parent  other and/or details of family history: \_\_\_\_\_

**DEVELOPMENTAL AND SOCIAL HISTORY**

Pregnancy:  uncomplicated  substance exposure  prenatal care \_\_\_\_\_

Labor & Delivery:  uncomplicated  pre- or  post-term  vaginal or  C-section \_\_\_\_\_

Birth Wt.: \_\_\_\_\_ lbs & \_\_\_\_\_ ozs City of Birth: \_\_\_\_\_

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remained with bio-mother after birth, or  entered child welfare from hospital  
 Infancy:  with bio-parent  with child welfare \_\_\_\_\_  
 Milestones:  Unknown walked at \_\_\_\_\_ talked at \_\_\_\_\_ toilet trained at \_\_\_\_\_  
 Toddler Years:  with bio-parent  with child welfare \_\_\_\_\_  
 History of:  fire setting  cruelty to animals  bedwetting  other \_\_\_\_\_  
 Elementary Grades (academics/behavior/social):  N/A \_\_\_\_\_  
 Middle School/Jr. High (academics/behavior/social):  N/A \_\_\_\_\_  
 High School (academics/behavior/social):  N/A \_\_\_\_\_

[JV-220(A) #7 and JV-220(B) #6] Current Ed. Setting: Grade: \_\_\_\_\_ School Name: \_\_\_\_\_  
 [JV-220(A) #7 and JV-220(B) #6] Type of Ed Setting:  regular  RSP (hrs/wk = \_\_\_\_\_)  SED  SDC  Home/Hosp.  
 NPS  Other \_\_\_\_\_

**MENTAL STATUS EXAMINATION**

[Include relevant information in JV-220(A) #7 and JV-220(B) #6]

Appearance/Grooming:  clean  grooming (wnl)  dirty  disheveled \_\_\_\_\_  
 Activity Level:  approp. for age  high for age  low for age \_\_\_\_\_  
 Abnormal Movements:  none  tics  TD \_\_\_\_\_  
 Attention Span:  good  fair  poor \_\_\_\_\_  
 Mood & Affect: \_\_\_\_\_  
 Speech & Thought Processes: \_\_\_\_\_  
 Thought Content:  hallucinations  delusions Specify: \_\_\_\_\_  
 Suicidal/Homicidal Ideas/Plans: \_\_\_\_\_

Impulse Control: \_\_\_\_\_  
 Alertness & Orientation:  person  place  time  purpose \_\_\_\_\_  
 Memory:  remote WNL  recent WNL  instant retention & recall WNL \_\_\_\_\_  
 Calculation: \_\_\_\_\_  
 General Fund of Information: \_\_\_\_\_  
 Abstraction: \_\_\_\_\_  
 Insight: \_\_\_\_\_  
 Judgement:  response to test question \_\_\_\_\_  social \_\_\_\_\_  
 Play Characteristics: \_\_\_\_\_  
 Other: \_\_\_\_\_

**BIOPSYCHOSOCIAL FORMULATION** (assessment of child's overall mental health [JV-220(A) #7; JV-220(B) #6]): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DIAGNOSTIC IMPRESSION** (see diagnosis form in chart for client's official diagnosis)

[JV 220(A) #14]

DSM-5/ICD-10 Code	DSM-5/ICD-10 Name
_____ / _____	
_____ / _____	
_____ / _____	
_____ / _____	

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**MANAGEMENT**

- Child was told in an age-appropriate manner about Dx, DDx, Tx Plan, Prognosis, course, alternatives to the recommended medications, the anticipated benefits and risks (for Tx vs non-Tx), and the possible side effects. **[JV-220(A) #17a; JV-220(B) #12a]**
- Child was informed that a request to the court for permission to begin and/or continue the medication will be made and that he or she may oppose the request. Child's response to this was:  agreeable  not agreeable

Briefly describe child's response: \_\_\_\_\_  
 \_\_\_\_\_

**OR**  Child has not been informed of the recommended medications, their anticipated benefits, and their possible adverse reactions because **[JV-220(A) #17b; JV-220(B) #12b]**: (1)  child lacks the capacity to provide a response (explain): \_\_\_\_\_

(2)  other (explain): \_\_\_\_\_  
 Child's present caregiver was informed of above information which included the recommended medications, the anticipated benefits, and the possible adverse reactions. **[JV-220(A) #18; JV-220(B) #13]** Possible adverse reactions include: \_\_\_\_\_

Emergency consent **[JV-220(A) #3]**:  Yes  No Why: \_\_\_\_\_

The caregiver's response to this was:  agreeable  other (explain): \_\_\_\_\_

**Psychotropic medications proposed as current treatment plan.** Mark each psychotropic as New (N) or Continuing (C) **[JV-220(A) #22; JV-220(B) #16]**

Medication	N or C	Max. Total mg/day	Treatment Duration**	Administration Schedule
Med: Class: Targets (Sxs expected to improve) <b>[JV-220(A) #13]</b> :				
Med: Class: Targets (Sxs expected to improve) <b>[JV-220(A) #13]</b> :				
Med: Class: Targets (Sxs expected to improve) <b>[JV-220(A) #13]</b> :				
Med: Class: Targets (Sxs expected to improve) <b>[JV-220(A) #13]</b> :				

\*\*Court approval to administer the medication will be limited to this time frame or six months from the date the court order is issued, whichever occurs first.

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Other Information about the prescribed medication(s) needed by the court (e.g., why prescribing more than one medications in the same class, why prescribing outside the approved range, or why prescribing medication not approve for a child of this age) [JV-220(A) #23; JV-220(B) #17]:  N/A  Other: \_\_\_\_\_

All essential lab tests have been performed [JV-220(A) #16; JV-220(B) #11]:  Yes  No, explain what tests were not done and why: \_\_\_\_\_

Psychotropic medications that will be stopped if proposed psychotropic medication(s) is/are court approved [JV-220(A) #24]

Medication	Reason for Stopping	Stop Immediately	Stop over time (details)
		<input type="checkbox"/> Y <input type="checkbox"/> N	
		<input type="checkbox"/> Y <input type="checkbox"/> N	
		<input type="checkbox"/> Y <input type="checkbox"/> N	
		<input type="checkbox"/> Y <input type="checkbox"/> N	

Requests for more information discussed and  consented to /  refused by parent/caregiver.

Conner's parent & teacher questionnaire  Hospital/Clinic Records from: \_\_\_\_\_

Requested Phys. Exam/Lab results  CBC with  SMA7  SMA12  LFT  RFT  TFT  UDS  U/A  HCG

EKG  Other: \_\_\_\_\_

Therapeutic services, other than medication, in which the child is enrolled or is recommended to participate in during the next six months [JV-220(A) #19; JV-220(B) #15]: enrolled recomm.

- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. <input type="checkbox"/> Group Therapy (freq: _____)  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <input type="checkbox"/> Individual Therapy (freq: _____) <input type="checkbox"/> Family _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <input type="checkbox"/> Milieu therapy (explain): _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. <input type="checkbox"/> Therapeutic Behavioral Services (TBS) _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| e. <input type="checkbox"/> Therapy for children on the autism spectrum _____                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. <input type="checkbox"/> Cognitive Behavioral Therapy (CBT) _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| g. <input type="checkbox"/> Wraparound Services _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. <input type="checkbox"/> American Indian/Alaska Native healing and cultural traditions _____    | <input type="checkbox"/> | <input type="checkbox"/> |
| i. <input type="checkbox"/> Speech therapy _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. <input type="checkbox"/> Intensive Home-Based Services (IHBS) _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| k. <input type="checkbox"/> Other modality (explain): _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. <input type="checkbox"/> Case Management (explain focus): _____                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| m. <input type="checkbox"/> Support Services recommended: _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE:** Information that is mandatory for the court review process (e.g., significant side effects, warnings/contraindications, drug interactions) must be attached to the JV-220(A) Physician's Attachment [JV-220(A) #20]. Provide additional information regarding the medication treatment plan and follow up [JV-220(A) #21; JV-220(B) #14]:  N/A – No Additional Information needed  Other: \_\_\_\_\_

Summary of treatment plan [JV-220(A) #8 – tx plan]:  Psychiatric Services (freq: \_\_\_\_\_) a n d : \_\_\_\_\_

- Educational needs discussed with parent/caregiver and advised him/her on communication with schools \_\_\_\_\_
- Advised parent/caregiver on emergency measures, which were:  understood  not agreed to  agreed to \_\_\_\_\_
- Further tests recommended: \_\_\_\_\_
- Informed consent for meds given ( not given) and signed by: \_\_\_\_\_
- Return to clinic \_\_\_\_\_
- Other: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_

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