CAMHS ON-CALL SUMMARY/ INITIAL ASSESSMENT FORM

To be completed on all patients assessed on-call and faxed to appropriate community team/Emergency Medicine Consultant and GP. Retain original on patient's file.

Assessment Date and Time:………………………………………. Emergency ○ Routine ○

1. GENERAL INFORMATION:

Name of Child/ Adolescent:…..……………………...

DOB…………….. Age…………………. Home Address………………………………………..

………………………………………….. Sector team………………………………………….

Mother's Name/Address/Phone no……………………………………………………………..

Fathers Name/Address/Phone no……………………………………………………………….

Name of School/Class /Phone no……………………………………………………………….

Care status/Concerns ………………………………………………………………………………..

Social services input YES ○ NO ○ If YES specify………………………………………..

………………………………………………………………………………………………………..

GP's Name and Address……………………………………………………………………………..

Location of assessment:…………………………… Consultant on-call:…………………………..

Assessed by :……………………. Present at Assessment:……………………………………….

Consent obtained ……………………………………………………………………………….

Brief summary of findings ………………………………………………………………………..

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Outcome of Assessment/Follow-up plan……………………………………………………………

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Discussed with ……………………………………………………………………………………

Signed…………………………………………. Date……………………………………….

2. REFERRAL INFORMATION:

Referred By:……………………………………………………………………………………….

Given Reason for Referral: …………………………………………………………….............

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Other Service Involvement:

A. Previous Mental Health Contacts:………………………………………………………

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B: Any other Agencies:…………………………………………………………………….

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3. PRESENTING COMPLAINTS/ EXPECTATIONS:

(Brief description in own words, list problems)

Parental View *(Brief description in own words, list problems/duration/expectations):*

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Child/ Adolescent's own view *(Brief description in own words, list problems/duration/expectations):*

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4. HISTORY OF PRESENTING COMPLAINTS ***(*** *Detailed sequential description of each problem*):

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5. FAMILY HISTORY:

Include the following information: family at home, parents, siblings and impact of the clinical presentation; significant family members elsewhere; parental responsibility; Significant life events, and separations, current occupations & ages; physical, mental health and learning problems including treatment and impact in family members. Quality of family relationships and communication. Comment on parenting styles, support etc. ***record relevant negative information***

Genogram diagram:

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6. SOCIAL HISTORY

Housing……………………………………………………………………………………………..

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Care and Family arrangements and support……………………………………………………………..

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Alcohol and Drugs …………………………………………………………………………………….

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Forensic history…………………………………………………………………………………………

7. PAST MEDICAL HISTORY

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Medication/ Allergy history

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8. DEVELOPMENTAL HISTORY

Pregnancy and Birth*(including meds, smoking and alcohol intake during pregnancy , social support and post natal depression)*………………………………………………………………………………………

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Infancy, Bonding and Attachment ……………………………………………………………….

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Motor and sensory development *(milestones, etc)*……………………………………………………..

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Speech and Language development ………………………………………………………………..

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Cognitive development *(learning difficulties)*…………………………………………………………..

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Toilet training *(enuresis and encopresis)* ………………………………………………………...............

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9. EDUCATION

Schools (past and current; current class and teachers)……………………………………………

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Academic progress (including information on extra school resources)……………………………...

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Social progress (friendships, social skills, bullying etc)……………………………………………

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10. MENTAL STATE EXAMINATION

Observation of play and interaction with family and clinician……………………………………........

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Appearance and behaviour………………………………………………………………………

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Speech, language and communication……………………………………………………………

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Mood………………………………………………………………………………………..

…………………………………………………………………………………………………

Affect……………………………………………………………………………………….

Thought……………………………………………………………………………………..

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Perception/Hallucination………………………………………………………………………….

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Suicidal/Homicidal ideations……………………………………………………………………...

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Cognition………………………………………………………………………………………….

Insight……………………………………………………………………………………………..

11. PHYSICAL EXAMINATION *(if necessary)*………………………………………………

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12.RISK ASSESSMENT (*Pls the tick appropriate box*)

Suicide and safety	**YES**	**NO**
Does the child have a history of suicide attempts? (If so provide details below)		
Is the child currently experiencing suicidal ideation?		
Is there a family history of suicide?		
Within the child's social network have there been instances of suicide or suicide attempts? If so, when? (Provide details below)		
Has the child experienced or is the child currently experiencing an event, which may be perceived as traumatic (e.g. Bullying, Physical/Sexual Abuse, Diagnosis of a Physical/Mental Illness etc.)		
Has the child experienced a significant loss either recently or in the past? (Family member, Relationship, Pet etc.)		
Has the child exhibited or is the child currently exhibiting signs of inappropriate sexual behaviour?		
Has the child in the past or is the child currently presenting with behavioural problems?		
Has the child a history of absconding?		
Is the child compliant with his/her current treatment plan?		

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Self-Neglect	**YES**	**NO**
Does the child have a history of self-neglect? (e.g. poor hygiene, inadequate dietary intake etc.)		
Does the child have a history of an eating disorder or body image problems?		
Does the child have low self-esteem?		
Does the child have difficulty communicating his/her needs?		
Are there significant financial constraints that may affect the child's ability to self-care?		

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Violence and Aggression

	YES	NO
Does the child have a history of violence or aggression towards adults, children, peers or animals?		
Has the child ever made specific threats of harm towards others?		
Does the child often talk about death, killing or weapons?		
Do TV shows; films or games of a violent nature fascinate the child?		
Does the child have access to, or carry weapons?		
Is the child experiencing a psychotic episode with thoughts of violence?		

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Drugs and Alcohol

	YES	NO
Has the child a history of drug or alcohol abuse? (If so give details)		
Has any member of the child's family a history of drug or alcohol abuse?		

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13. FORMULATION (*predisposing, precipitating, perpetuating and protective factors)*..

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14. ICD 10 MULTIAXIAL DIAGNOSIS *(Axis 1 to 6)*

Axis 1(Clinical Psychiatric Syndrome) ………………………………………………………..

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Axis 2 (Specific disorders of psychological development) ……………………………………..

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Axis 3 (Intellectual ability)……………………………………………………………………

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Axis 4 (Medical Conditions) …………………………………………………………………

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Axis 5 (Associated Psychosocial Situations) ………………………………………………….

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Axis 6 (Global Assessment of Psychosocial Disability 0-6)……………………………………

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15. PLAN OF MANAGEMENT

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