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

UAMS Medical Center

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

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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	[ ] sexually acting out*	[ ] trauma*
[ ] history of threatening suicide	[ ] delusions/hallucinations	[ ] physical aggression*
[ ] agitation	[ ] hyperactivity	[ ] property destruction*
[ ] feelings of hopelessness	[ ] depression	[ ] fire setting
[ ] recent family/ friend loss	[ ] weight gain/ loss	[ ] death in the family
[ ] disruption of support system*	[ ] self-injury	[ ] anxiety
[ ] cruelty to animals	[ ] disorganized speech	[ ] paranoia
[ ] thoughts of harming others	[ ] catatonic behavior	
[ ] poor sleep patterns	[ ] panic attack	

Please explain any starred (*) items: _____
_____
_____
_____
_____
_____

Prior **Outpatient** Treatment: (Including school-based and day treatment)

Facility	Start	End	Reason for Treatment	Therapist Name, Phone Number

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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

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UAMS Medical Center

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

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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?
_____
_____
_____
_____

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