Request for Services - Child

TODAY'S DATE: _____

OFFICE USE ONLY

CLIENT NAME: _____ CHART NUMBER: _____

FORM COMPLETED BY: _____ **RELATION TO CHILD**: _____

CHILD'S LEGAL NAME: _____ **SEX:** ☐ FEMALE ☐ MALE
LAST **FIRST** **MIDDLE NAME**

CHILD'S DATE OF BIRTH: _____ **AGE:** _____ **SOCIAL SECURITY NUMBER:** _____

ADDRESS (CITY / STATE / ZIP): _____

Family Information

PARENT/LEGAL GUARDIAN NAME: _____ **PHONE**: _____

ADDRESS (CITY / STATE / ZIP): _____ **EMAIL:** _____

(☐ Same Address listed for child)

RELATIONSHIP TO CHILD: ☐ Biological mother ☐ Biological father ☐ Step-parent ☐ Legal Guardian ☐ Other:

_____

With whom does the child live? ☐ Birth Parent(s) ☐ Adoptive Parents ☐ Foster Parents ☐ Legal Guardian ☐ Other _____

Who has Legal custody of this child? _____

If child lives with anyone other than birth parents or parents are divorced, documentation of legal custody is required prior to or at the time of intake. **Is DHS or OJA currently involved with your child?** ☐ Yes ☐ No

EMERGENCY CONTACT NAME: _____ **PHONE**: _____

RELATIONSHIP TO CHILD: ☐ Biological mother ☐ Biological father ☐ Step-parent ☐ Legal Guardian ☐ Other: _____

Has a member of your family served in the military? ☐ Yes ☐ No

Reason for Seeking Services

PLEASE DESCRIBE PROBLEMS OR CONCERNS RELATED TO SEEKING MENTAL HEALTH SERVICES FOR THIS CHILD:

_____

_____

ARE YOU CONCERNED FOR THIS CHILD'S SAFETY (statements or suspicion of harm to self or others)? ☐ Yes ☐ No

IF YES, DESCRIBE: _____

WAS THIS CHILD EVER ADMITTED INTO AN INPATIENT OR CRISIS UNIT FACILITY? ☐ Yes ☐ No

IF YES, WHEN AND WHERE: _____

WHO REFERRED THE CHILD TO RED ROCK SERVICES?

_____

SERVICES INTERESTED IN FOR CHILD (please check all that apply):

☐ Therapy/Counseling ☐ Systems of Care (SOC)/Wrap-around ☐ Case Management ☐ Medication Clinic ☐ IPIC

☐ I am not sure- I would like more information about services at Red Rock.

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Household Information

ANNUAL HOUSEHOLD INCOME: _____ **NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD:** _____

Insurance Information

DOES THE CHILD RECEIVE SSI/SSDI BENEFITS? ☐ Yes ☐ No **DOES THE CHILD HAVE HEALTH INSURANCE?** ☐ Yes ☐ No

IF YES, PROVIDE THE NAME OF INSURANCE: _____ **ID NUMBER:** _____

Demographics

CHILD'S RACE (CHECK ALL THAT APPLY): ☐ AMERICAN INDIAN or ALASKAN NATIVE ☐ BLACK / AFRICAN AMERICAN ☐ ASIAN

☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ WHITE/ CAUCASIAN

CHILD'S ETHNICITY: ☐ HISPANIC ORIGIN ☐ NOT OF HISPANIC ORIGIN **PREFERRED LANGUAGE:** ☐ ENGLISH ☐ OTHER(S) _____

Substance Use

DOES THE CHILD USE TOBACCO PRODUCTS? ☐ Yes ☐ No IF YES, HOW MANY PER DAY? _____

DOES THE CHILD USE ALCOHOL OR OTHER DRUGS? ☐ Yes ☐ No IF YES, WHAT SUBSTANCE? _____

AND HOW OFTEN? _____

Medications

DOES THE CHILD TAKE ANY MEDICATIONS? ☐ **Yes** ☐ No **IF YES, COMPLETE BELOW RELATED TO MEDICATIONS**

LIST MEDICATIONS CHILD IS CURRENTLY TAKING (INCLUDE AMOUNT/DOSAGE AND HOW OFTEN):

_____

_____

PRESCRIBER OF MEDICATIONS CHILD IS CURRENTLY TAKING: ☐ Primary Care Physician ☐ Psychiatrist ☐ Other: _____

PHYSICIAN NAME: _____ **AGENCY/CLINIC NAME:** _____

PHONE: _____ **ADDRESS:** _____

Outside Provider(s)

IS THIS CHILD CURRENTLY RECEIVING MENTAL HEALTH SERVICES OUTSIDE OF RED ROCK (e.g. therapy, medication, etc.)?

☐ Yes ☐ No **IF YES, PLEASE IDENTIFY: TYPE OF SERVICE** _____

AGENCY NAME: _____ **PROVIDER NAME:** _____

Education Information

CHILD'S CURRENT SCHOOL: _____ **GRADE LEVEL:** _____

LIST THE NUMBER OF DAYS WITHIN THE LAST 3 MONTHS THE CHILD HAS BEEN:

ABSENT FROM SCHOOL: _____ **SUSPENDED FROM SCHOOL:** _____ **SUSPENDED FROM DAYCARE:** _____

Additional school support (IEP, special education, etc.) _____

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I and/or my parent/guardian consent to have treatment at Red Rock Behavioral Health Services (RR). I authorize RR to use/disclose my health information to obtain payment for the services received. I understand that a bill may be sent to me and/or a third-party payer. I and/or my parent/guardian assign all insurance benefits for which I am eligible to RR. This agreement will remain in effect until revoked by me and/or my parent/guardian in writing, or when all third party claims are satisfied. I understand that I and/or my parent/guardian are financially responsible for all charges. I have read, or had this information read to me, and understand it.

_____ _____

Child's Signature if over age 16 **Date**

_____ _____

Parent/Guardian Signature (If applicable) **Date**

TODAY'S DATE: _____

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)
RED ROCK STAFF: ENTER INTO AVATAR-PHQ9

☐ **Child is under 11 years of age (Do not complete this form).**

☐ **Child is 12 years of age and above (Please complete this form).**

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle the appropriate response)*	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you circled <u>any</u> problems above, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or take care of other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

<u>RED ROCK STAFF Signature and Date:</u> _____

_____

<u>Red Rock staff above entered the scores on this form into AVATAR and the form was scanned into client chart and labeled RFS/PHQ9.</u> _____

CLIENT NAME:_____ CHART #:_____

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