ENTER PCP NAME/PRACTICE HERE

Dear Families,

Due to the great shortage of child mental health professional in our region, we have entered into an agreement with the University of Florida, Department of Psychiatry, Division of Child and Adolescent Psychiatry. This agreement, called a Behavioral Health Collaborative, provides our practice with consultation and advice on how we can best deliver mental health services for your child, and obtain assistance on referrals for counseling therapy services. We will have consultation from child & adolescent psychiatrists, psychologists, and a licensed clinical social worker (LCSW). When you provide written consent, we will submit a consultation request to the hub to help your child. There are several steps that will occur as a result, all of which are essential and necessary to deliver these enhanced services:

- You may be contacted by the LCSW or Post Doc from UF Department of Psychiatry to obtain important information from you and your child. This assessment will be phone or televideo (via Zoom) and takes about 20 minutes. It is essential to have this information to provide consultation to your child's primary care provider (PCP). Please collaborate on scheduling and making this contact a priority to expedite the consultation.
- If your child has received services for behavioral health services by another provider, you will be asked to sign release of information permissions to obtain prior records, and possibly retrieve them in person if necessary. It is very important we can review all this information so we can make appropriate recommendations for your child's care.
- Your Primary Care Provider from our office will have a telephone conversation with the Psychiatrist or Psychologist to discuss your child's needs; this is referred to as a "doc-to doc" consultation. During this conversation the Psychiatrist/Post Doc will make recommendations to your primary care provider regarding his/her treatment. Most of our work is accomplished through such consultation. Your child's PCP will relay these recommendations during your next visit, or sooner if warranted.
- In some cases, you and your child may be asked to participate in a 60-minute telehealth evaluation via Zoom with a Psychologist or Psychiatrist, either direct to your home or to an exam room at our office. Based on this telehealth appointment, the psychiatrist will communicate recommendations to your child's primary care provider.
- If it is deemed appropriate, your child may be referred for therapy at local or regional mental health services and the LCSW or Psychologist will help with that referral.
- The level of service delivered is determined by mutual agreement between our team and your child's PCP, taking into consideration the family's input. However, it is totally up to you to decide participation by your child's PCP in this consultation program.

We are committed to the care of your child and strive for the best possible outcomes with his/her care. Likewise, your participation in the collaborative is also a commitment on behalf of your child.

[Phone]
[Email]
[Website]
[Street Address, City, State, Zip Code

Mental Health Background Information

MRN sticker

Name of the person completing this form:
Relationship to the child:
Child prefers being called:
Religion:

Please list who lives in the same household as the child:

Name	Sex	Age	Relationship to Child

SOCIAL HISTORY:

Name of current school:	
Current grade:	Did the child repeat any grades?
Does the child have a 504 plan or IEP?	Is the child in ESE or special needs classes?
Please list any school problems (behavioral or academic):	

DEVELOPMENTAL HISTORY:

Has anything significant occurred during the child's development years? (delays, not meeting milestones, etc.)

TESTING HISTORY:

	No	Yes
Any history of IQ or achievement testing?		
Ever been tested for hearing abnormalities?		
Ever been tested for speech/ language abnormalities?		
Has the child ever received occupational or physical therapy?		

MEDICATIONS:

Please list all **psychiatric** medication the child is **currently taking**:

Name of medication	Dose of medication	Who prescribes it?

Please list any **psychiatric** medications the child has **taken in the past**:

PAST PSYCHIATRIC HISTORY:

Has the child ever seen a **psychiatrist or therapist/counselor** before?

Name of provider	Dates seen	Reason

Has the child ever been admitted to a **psychiatric hospital**?

Name of the hospital	Dates	Reason

What are the main concerns that you have about the child's behavior or emotions?

How long have you had these concerns?

	No	Yes	Please describe/specify:
Has the child ever attempted suicide?			
Does the child engage in any self-harm behaviors (like cutting)?			
Has the child ever been violent?			
Has the child ever been aggressive?			
Does the child use alcohol?			
Does the child use tobacco or vape?			
Does the child use illegal drugs?			

FAMILY HISTORY:

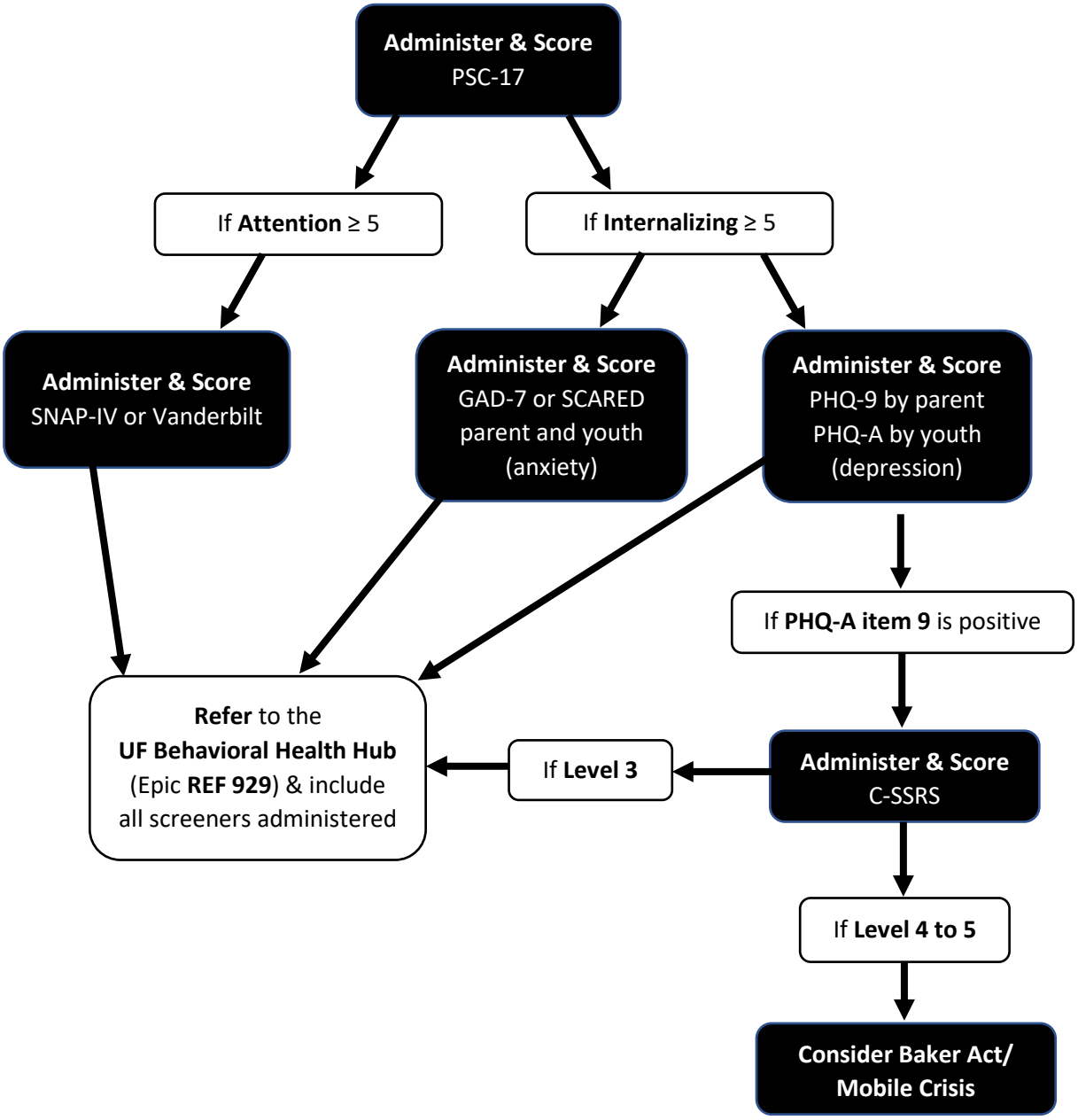
Please identify any known **psychiatric** illnesses in **blood relatives** of the child:

	Child's Mother	Child's Father	Child's siblings	Mother's side of the family	Father's side of the family
Anxiety					
Attention-deficit/hyperactivity disorder (ADHD)					
Autism					
Bipolar disorder					
Depression					
Eating disorder					
Intellectual disability or learning problems					
Psychosis					
Schizophrenia					
Substance/alcohol/drug misuse					
Suicide					

OTHER:

Has the child experienced…	No	Yes	Please describe/specify
Adoption			Are they aware?
Conflicts with parents			
Death of a parent, loved one, close friend			
Family financial problems			
Foster care/removal of child from home			
Illness in family			
Loss of home			
Other separation from parent/family			
Parent separation/divorce			
Unwanted pregnancy			
Victim of crime or violence			
Other:			
Please elaborate on any of the above and how they have affected the child, any symptoms as a result:			

Mental Health Screening Algorithm:
Patient of concern, decision to refer to UF Behavioral Health Hub



Abbreviation	Screening Form
PSC-17	Pediatric Symptom Checklist-17*
SNAP-IV	Swanson, Nolan, and Pelham (SNAP) Questionnaire – 18-item Scale*
Vanderbilt	NICHQ Vanderbilt Assessment Scale
PHQ-9	Patient Health Questionnaire*
PHQ-A	PHQ-9 modified for Adolescents/Teens
GAD-7	Generalized Anxiety Disorder 7-item Scale*
SCARED	Screen for Child Anxiety Related Disorders*
C-SSRS	Columbia Suicide Severity Rating Scale*
	***Available at:** https://bhh.psychiatry.ufl.edu/for-providers/provider-forms/*