Inpatient Agency Juvenile Data Report Form

Facility: ______________________________ Facility Code: ________ [ ][ ][ ][ ][ ][ ]
Chart # (if applicable)

_____________________________ _____________________________ _____
Patient Last Name ***(PLEASE PRINT)*** **First Name** **MI**

Soc. Sec. # [ ][ ][ ]-[ ][ ]-[ ][ ][ ][ ] **Date of Birth:** [ ][ ]/[ ][ ]/[ ][ ] (mm / dd / yr) **Age:** [ ][ ]

[ ] **Race:** 1=White/Caucasian 2=African American 3=American Indian 4=Alaskan Native 5=Asian 6=Other ________________

Sex: Male [ ] Female [ ]

Requests **(per court order)**
_____Evaluation/Diagnosis/Committability
_____Treatment/Service Recommendations
_____ Competency to Stand Trial
_____ Mental Condition (Insanity Defense)
_____ A&D Assessment _____Psychosexual
_____ MR assessment _____Other, Specify

[ ] **Court:** 1=Juvenile
2=Other ______________________________
County ______________________________________

Nature of Proceedings [ ] Crime: 1=Capital 2=Violent Felony 3=Violent Felony: Sex Offense 4=Non-Violent Felony 5=Misdemeanor 6=Status Offense 7=Unknown

[ ] Dependency/Neglect

Specify Charge(s): ____

CMHC Previously Providing Juvenile Evaluation: ____

[ ][ ]/[ ][ ]/[ ][ ] (mm / dd / yr) **Date Court Order Received** [ ][ ]/[ ][ ]/[ ][ ] (mm / dd / yr) **Date of Admission**

[ ][ ]/[ ][ ]/[ ][ ] (mm / dd / yr) **Date Letter Sent to the Court** [ ][ ]/[ ][ ]/[ ][ ] (mm / dd / yr) **Date of Discharge**

---**OUTCOME**---

Diagnosis: Axis I____
Axis II____
Axis III ____
Axis IV ______________________________ Axis V ____________

Competency: [ ] 1=Yes, CMHC follow-up 2=Yes, no CMHC follow-up 3=Yes, Residential Treatment 4=No, CMHC follow-up 5=No, Mentally Retarded 6=No, committable 7=Deferred 8=N/A 9=N/A, discharged from elopement

Insanity Defense Supported: Yes [ ] No [ ] N/A [ ] N/A, Discharged from Elopement [ ]

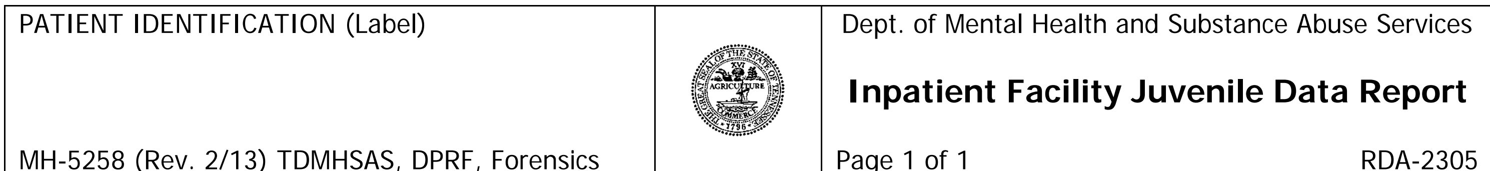
Committable: [ ] 1=Yes, Mentally Ill 2=Yes, Mentally Retarded 3=No, Referred to Community Services 4=No, Referred to Residential Services 5=No 6=N/A

Referred To:
[ ] Community Mental Health Services [ ] Residential Treatment
[ ] Residential Treatment with specialty program: [ ] Mental Retardation [ ] Sex Offender [ ] Substance Abuse
[ ] Other ____

Other Recommendations:____
____

Care Management/Follow-up Services: ______________________________________

Completed by: ______________________________________ **Date:** ______________



PATIENT IDENTIFICATION (Label)

Dept. of Mental Health and Substance Abuse Services

Inpatient Facility Juvenile Data Report

MH-5258 (Rev. 2/13) TDMHSAS, DPRF, Forensics

RDA-2305