ARIZONA DEPARTMENT *of* CHILD SAFETY

# Outpatient Assessment Report

*Child's Name* | *Date of Birth* | *Date of Report*

## A. Assessment

I am the licensed ☐ psychiatrist ☐ psychologist or ☐ physician ☐ psychiatric/mental health nurse practitioner (check one) who conducted an outpatient assessment of the above-named child on _____ *Date* which included the following as required by A.R.S.§ 8-271(5) and A.R.S. § 8-272(B):

***Initial all elements that apply.***

| | |
|---|---|
| | A psychiatric or psychological assessment, including a clinical interview with the child. |
| | An explanation to the child of the least restrictive alternatives available to meet the child's mental health needs. |
| | A determination as to whether the child may be suffering from a mental health disorder, is a danger to self or others or is persistently or acutely disabled or gravely disabled. |
| | A review of the child's medical, social and psychological records, if available. |
| | A determination as to whether the child needs an inpatient assessment or inpatient psychiatric acute care services and whether inpatient psychiatric acute care services are the least restrictive available alternative. |

## B. Outpatient Assessment Recommendations

***Based on the foregoing assessment, I recommend that the child be either. Initial all elements that apply.***

| | |
|---|---|
| | Admitted to a psychiatric acute care facility for an inpatient assessment. |
| | Admitted to a psychiatric acute care facility for inpatient psychiatric care services. |
| | (If this alternative is checked, proceed to Part C below) |
| | Provided with residential treatment services. |
| | (If this alternative is checked, proceed to Part D below) |
| | Discharged to an entity and provided with outpatient treatment services. |
| | Discharged to the entity without further psychological or psychiatric service because the child does not suffer from a mental disorder, is not a danger to self or others or is not persistently or acutely disabled or gravely disabled. |

## C. Recommendation For Inpatient Psychiatric Acute Care Services

My recommendation that the child receive acute inpatient psychiatric services is based on the following:

☐ **1** Inpatient psychiatric acute care services are the child's best interest for the following reasons:

☐ **2** Inpatient psychiatric acute care services are the least restrictive alternative for the following reasons:

☐ **3** The diagnosis of the child's condition requiring inpatient psychiatric acute care services is:

☐ **4** The estimated length of time the child will require inpatient psychiatric acute care services is:

## D. Recommendation For Residential Treatment Services

My recommendation that the child receive residential treatment services is based on the following:

☐ **1** Residential treatment services are in the child's best interests for the following reasons:

☐ **2** Residential treatment services are the least restrictive treatment available for the following reasons:

☐ **3** The child's behavioral, psychological, social, or mental health needs require residential treatment services for the following reasons:

☐ **4** The estimated length of time the child will require residential treatment services:

## E. Additional Notes

I am the Medical Director or designee of _____. Pursuant to A.R.S § 8-272 (F)(2), I have determined that
*Name of Inpatient Psychiatric Acute Care Facility*

this facility's services are appropriate to meet the current behavioral health clinical needs of the youth named above.

A.R.S. § 8-201 (19) defines a "medical director of a mental health agency" as a psychiatrist, or licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the agency as the person in charge of the medical services of the agency; or a psychiatrist designated by such a governing body to act for the director. The term includes the superintendent of the State Hospital.

_____
*Psychiatrist, Psychologist or Physician Performing Assessment, Psychiatric/Mental Health Nurse Practitioner Name (Printed)*

_____ _____
*Email Address* *Facility Phone No.*

_____ _____
*Psychiatrist, Psychologist or Physician Performing Assessment, Psychiatric/Mental Health Nurse Practitioner Signature* *Date of Report*