Optum

The Format and Required Elements of a Probation Psychiatric Evaluation

The **Format** and **Elements** described represent the minimal requirements required of a CWS or Probation Psychiatric Evaluation. The required "Elements" describes the information that should be addressed under each heading/section of the report. If an element is not included in the report, it is necessary to provide a valid reason. Additional relevant information may be included in the evaluation report.

Reports should be submitted with a professional letterhead on the first page of the report that includes contact information including the provider's office/mailing address and phone number. Please be advised that an attorney may release the evaluation report directly to the client or the parents/guardians of the client. An asterisk (*) indicates that this element is required. If it is not included in report, the report will not be accepted.

***Client's Name**: Fill in the name of the client.

***D.O.B.**: ____ years, ____month

***Gender/Ethnicity/Cultural/Religious Background**: List relevant ethnic, cultural and/or religious identifiers.

***Primary Language**: List primary language used and any other languages that the client utilizes.

***Location of Evaluation**: List location where the evaluation took place.

***Date of Evaluation**: List all the dates of when interviews and evaluation took place.

***Date of Report**: List the date the report was written.

***CWS Case Number/Probation Regis Number**:

***Protective Worker/Probation Officer's Name**:

***Protective Worker/Probation Officer's Phone Number**:

***Protective Worker/Probation Officer's Fax Number**:

***Minor's Attorney's Name (for use in Probation cases only)**:

***Minor's Attorney's Phone Number (for use in Probation cases only)**:

***Minor's Attorney's Fax Number (for use in Probation cases only)**:

***Referral Questions**: Please list verbatim the specific questions posed by the requestor (i.e., PSW, PO, and Judge). Protective issues in Child Welfare Services cases and dangerousness (if pertinent) in Probation cases should be addressed.

***Sources of Information**: List all sources of information reviewed or used in the development of the resulting opinion and report. Include phone conversations, other clinicians' reports, psychological testing reports, and people interviewed or who completed standardized questionnaires as collateral data. If no collateral data were obtained via interview or data collection, please list here the extenuating circumstances that prevented this from occurring.

***Confidentiality Advisement**: Confirm that the client has been advised that this evaluation is for purposes of writing a report for the Court and that any information obtained during this evaluation may appear in such a report. Indicate that the client understood/did not understand the nature of the evaluation and limits of confidentiality. The reader of the report should also be advised that the report contains sensitive information subject to misinterpretation by those untrained in interpreting psychiatric evaluation data.

***Background Information**: Include how the client came to the attention of the Court, how CWS/Probation is involved in the case, police involvement, prior Court actions, and information about the client's placement. Briefly include results from previous evaluations.

***History of Present Illness**: Incorporate details of signs and symptoms of current psychiatric illness, time course, stresses and contributing events, current and past medications and their effects/side effects.

***Past Psychiatric History**: Include prior episodes of mental illness, hospitalizations, medications taken, treatments, and placements.

Past Medical History: Include prior or existing medical conditions, medications, operations, and hospitalizations.

Family History: Include psychiatric, medical, and school function history.

Developmental History: Include pregnancy/prenatal history, delivery and postnatal events, highlights of early development, and ongoing developmental difficulties.

Substance Abuse History: Include substances used, treatment received, and ongoing symptoms or disability related to substance use/abuse including the use/abuse of prescription medications.

Sexual History: Include information on gender identity, sexual activity, signs or symptoms of dysfunction, and ongoing issues.

School History: Include current school placement, school functioning, presence of an Individualized Education Plan (IEP), and current remediation.

Social/Cultural/Family Events History: Include major family events like divorces, moves, immigration.

Legal/Social Services History: Include information about arrests, convictions, probation requirements, placements, CWS contacts, etc.

***Mental Status Exam**: Include information about overview (level of consciousness, appearance, dress and hygiene, attitude, motor behavior); speech and language (fluency, rate, quantity, loudness, clarity, receptive or expressive abnormalities, vocabulary); mood and affect (including suicidal ideation and behavior, homicidal ideation and behavior); thought processes (form, content, and perceptions); obsessions and rituals; cognitive functioning including short term memory, long term memory/memory consolidation, abstract reasoning, and cognitive flexibility; insight and judgment, and interpersonal style as manifested during the evaluation.

***Case Formulation/Summary**: Provide a relatively brief biopsychosocial summary of the client. Explain diagnostic symptoms within the client's particular context, how these symptoms contributed to the process of differential diagnosis, and conceptual understanding of the client.

***Diagnoses**: Provide diagnostic impressions according to the Diagnostic and Statistical Manual of Mental Disorders-5-TR (DSM-5-TR). Corresponding diagnostic codes from the ICD-10 (International Classification of Diseases) are required. The principal diagnosis should be listed first, with additional diagnoses listed thereafter, in order of significance. V codes are appropriate if they are the focus of clinical attention. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-5-TR). Simply listing diagnostic rule-outs is not helpful, as the client was referred for a psychological evaluation specifically to rule-out competing diagnoses.

***Recommendations**: Answer the specific referral questions using information related to the diagnoses and/or case summary and conceptualization. Offer treatment recommendations that are supported by the evaluation documentation, including types of medications as well as other therapeutic interventions to address the psychiatric and/or physical health concerns. Provide prognosis regarding psychiatric functioning; ensure prognosis addresses the legal time limits of the case if this is a CWS referral. If asked to address placement issues, discuss lowest level of placement needed to safely treat client without specifically naming a particular program. Opinions about protective issues or dangerousness in the community are helpful if pertinent.

***Signature and Title**: Please sign and date the report. Please do not use a computer-generated signature.