CAMHS Inpatient Psychiatric Assessment

Patient Details	
Name:	
Address:	
Date of Birth:	
Date of assessment:	
Time of Assessment:	

Parent(s)/Guardian(s) Details	
Name:	**Address:**
Contact No.:	

Name:	**Address:**
Contact No.:	

Please select if the following have been discussed and/or obtained	
Consent forms signed by parent/guardian	☐ Yes ☐ No, if No give details:
Introduction to CAMHS and explanation of assessment process	☐ Yes ☐ No, if No give details:
Limits of confidentiality – including risk and child protection (Children's First)	☐ Yes ☐ No, if No give details:
Compliments/complaints procedure	☐ Yes ☐ No, if No give details:
Attendance Policy	☐ Yes ☐ No, if No give details:
Data Protection explained	☐ Yes ☐ No, if No give details:

Professional help/Intervention received to date

Please list any professionals or services currently or previously involved with the child/young person and/or family (e.g. TUSLA, GP, Barnardos, school support, NEPS, psychologist, social work, SLT, OT, CDNT, private therapy).

Name	Profession	Organisation	Contact Number	Currently Involved
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Referred Concern

Goals of Referral Agent

Presenting problems including History of young person – *onset of symptoms over time, current symptoms and impact on functioning, features of presenting difficulties, i e mood disorder, anxiety disorder, psychosis, eating disorder etc.*

Review of co-morbid health difficulties

Referrers Risk Assessment – self-harm, aggression, risk-taking behaviours, abuse, etc

Young persons understanding of difficulties and goals/expectations of inpatient treatment

Presenting problem continued: Young Person

Presenting Problem (incl. history of): Collateral History – parents/guardians/other(cont.)

Previous Psychiatric History

Drugs, Alcohol and Forensic TX

Medical History: (include medical conditions and treatment; and all current medications, allergies)

Young person's personal and developmental history: (pregnancy, delivery, milestones, temperament, attachments, life events, schooling, relationships, social activities and hobbies.)
Educational history: (Preschool, primary, post primary. Current school year, level of functioning – academics and peers, history of bullying, and changes in performance of attendance.)
Family History/ Genogram

Family/Household Composition		
Detail	**Age**	**Occupation/School**
Parent/Guardian		
Parent/Guardian		
Siblings		
Others living in the home		

Current Family Stressors/Relationships between family members

Mental State Assessment

(Including appearance, behaviour, eye contact, rapport, mood, affect, thoughts and perceptions, cognition, judgement and insight.)

Risk Assessment: (Please tick if relevant and detail below)

DSH Suicide ☐ D&A ☐ Forensic ☐ Neglect ☐ Abuse ☐ Other ☐

Details:

Provisional Multi-Axial Classification ICD code
AXIS I:
AXIS II:
AXIS III:
AXIS IV:
AXIS V:
AXIS VI:
Intake Summary/Formulation
Intake Management plan

Medication on admission	
Admitting Clinician:	Admitting Consultant:
Name:	Name:
Signature:	Signature:
IMC:	IMC:
Date:	Date: