Parent Request for Psychiatric Evaluation page 1 of 10 pages

Name of Referred Person	
Date of Birth	/ / **Date information provided>** / / /
Name of person completing form	**Relationship to child**
Address	
Phone	
E-mail address	
School	

Go to www.JeffTurley.com

Other ways to complete this form:

1. In an internet browser (preferred)
2. Download MS Word document and complete by typing in fields. Print or submit as e-mail attachment to doctor@JeffTurley.com

Consent Statement: By submitting this form I attest that I have legal authority to consent to a psychiatric consultation regarding the above-named child.

Signed: _____ Date _____

School Consultations: I understand that the information gathered for the consultation will be summarized in a report distributed to appropriate school personnel for the sole purpose of determining educational needs. The consultation alone does not establish a confidential medical record, and does not establish an on-going treatment relationship with Dr. Turley. Records derived from the information I submit will be protected by the Family Educational Rights and Privacy Act (FERPA). I know I can read about these rights at the U.S. Department of Education web site at www.ED.gov. Initials: _____

Treatment Consultations: I understand that the information gathered for the consultation will be summarized in a report protected as a confidential medical record by the Health Insurance Portability and Accountability Act (HIPAA). Reports will be distributed only in response to my written release, and only to those parties that I designate. I know I can read about HIPAA rights at the U.S. Department of Health and Human Services web site at www.hhs.gov/ocr/hipaa/. Initials: _____

Security of information: all reasonable precautions will be taken to maintain the confidentiality of the information to be submitted on this form

Parent Request for Psychiatric Evaluation page 2 of 10 pages

<Allow 45-60 minutes to complete this 10 page form thoroughly>

What questions would you like to have the requested evaluation answer?

1._____

2._____

3._____

Please note areas of active concern about the referred child (specifics will be recorded on later pages):

	YES	NO
Behavior dangerous to others	Y	N
Behavior dangerous to self	Y	N
Experimenting with drugs or alcohol	Y	N
Defiant of adult authority	Y	N
Problems with focus and attention	Y	N
Depressed moods	Y	N
Elevated, irritable, or manic moods	Y	N
Anxieties, fears, phobias	Y	N
Confusion about what is real and what is not	Y	N

Duration of symptoms is an important diagnostic consideration. If mood disturbance is a concern, how long are the continuous periods when mood seems distinctly abnormal and the child is not behaving like his/her usual self?

	Minutes	Hours	Days	Weeks	Months
Duration of continuous mood disturbance					

Describe the student's primary **strengths** as a person:

_____

_____

_____

_____

Describe his/her main **limitations/challenges**

_____

_____

_____

_____

_____

_____

Circle:

Reading	Excellent	Above average	Average	Somewhat of a problem	Problematic
Math	Excellent	Above average	Average	Somewhat of a problem	Problematic
Written Expression	Excellent	Above average	Average	Somewhat of a problem	Problematic
Relationships with peers	Excellent	Above average	Average	Somewhat of a problem	Problematic
Following directions	Excellent	Above average	Average	Somewhat of a problem	Problematic
Disrupting classes	Excellent	Above average	Average	Somewhat of a problem	Problematic
Completing assignments	Excellent	Above average	Average	Somewhat of a problem	Problematic
Organizational skills	Excellent	Above average	Average	Somewhat of a problem	Problematic

If the child has an Individualized Education Plan (IEP):

Nature of disability	
Services offered	
Your suggestions for improvement	

Use the table below to describe the important relationships in the child's life

Name	**Age**	**Relation**	**How does the child get along with this person?**	**Comments**
Example: James	43	Father	Very well	Father gets exasperated with his behavior

Your notes regarding relationships and social functioning:

TRAUMAS	YES	NO	NOTES
Victim of violence	Y	N	
Victim of sexual abuse	Y	N	
Witnessed violence	Y	N	
Separation from parent (s)	Y	N	
Death in family	Y	N	
Out of home placement	Y	N	
Divorce/separation	Y	N	
Other traumatic experience	Y	N	

Typical punishment	Child's Reaction

	Consistency		
Punishments	Very	Somewhat	Not
Rewards	Very	Somewhat	Not

Describe any factors that limit how consistently parents can enforce limits or rules: _____

_____

Developmental Milestone			Notes
Crawling, walking	Normal	Delayed	
Toilet training	Normal	Delayed	
Speech and language	Normal	Delayed	
Self-care (dressing, bathing)	Normal	Delayed	
Social skills	Normal	Delayed	
Play	Normal	Delayed	
Self-control	Normal	Delayed	
Other (describe below)	Normal	Delayed	
	Normal	Delayed	

Temperament: as a baby or young child, was he/she:

	YES	NO	Notes
Easy going	Y	N	
Tolerant of frustration	Y	N	
Confident	Y	N	
Tried new things	Y	N	
Social, outgoing	Y	N	
Quiet	Y	N	
Calm	Y	N	
Safe	Y	N	
Kind, sensitive to others	Y	N	
Flexible	Y	N	
Independent	Y	N	

Medical problems, past or present

Drug allergies	Now	Past
Heart (cardiac)	Now	Past
Hypertension	Now	Past
Seizures or Epilepsy	Now	Past
Head injury	Now	Past
Migraines	Now	Past
Kidney/bladder	Now	Past
Bones/muscles	Now	Past
Thyroid	Now	Past
Diabetes	Now	Past
Eye disease	Now	Past
Stomach/bowel	Now	Past
Lungs/asthma	Now	Past
Gynecological	Now	Past
Other(specify)	Now	Past

Your notes regarding medical problems, past or present: _____

_____

_____

Medical Release of information:

I ***agree*** to allow exchange of information between Dr. Turley and the primary medical provider:

Sign:_____ Date:_____

Provider's Name: _____ Phone: _____

I ***decline*** the option of exchange of information between Dr. Turley and the primary medical provider:

Sign:_____ Date:_____

Family History	Yes	No	Who? (Relation to child)
Heart disease	Y	N	
Diabetes	Y	N	
Psychosis, schizophrenia, or nervous breakdowns	Y	N	
Psychiatric Hospitalizations	Y	N	
Bipolar disorder or manic-depressive disorder	Y	N	
Explosive temper/violent behavior	Y	N	
Suicide or suicide attempts	Y	N	
Alcohol or drug addictions	Y	N	
Severe depression	Y	N	
Severe anxiety or panic attacks	Y	N	
Attention-deficit Hyperactivity Disorder (ADHD)	Y	N	
Antisocial or criminal behavior	Y	N	
Other conditions (specify)	Y	N	

Therapy: describe any past or **current counseling** (how long is/was the therapy, how effective is/was the therapy, etc.

Therapist	Now	Past	Notes (effectiveness, etc0

Psychiatric Hospitalizations? ☐**Yes** ☐**No** **If yes, write below**

When	Where	Why

Psychiatric Medication Treatment

Name of medicine	Now	Past	Target	Effects
Adderall (amphetamine salts)	N	P		
Ritalin (methylphenidate)	N	P		
Concerta (methylphenidate)	N	P		
Metadate (methylphenidate)	N	P		
Focalin (dexmethylphenidate)	N	P		
Daytrana (methylphenidate patch)	N	P		
Vyvanse (lisdexamfetamine dimesylate)	N	P		
Strattera (atomoxetine)	N	P		
Clonidine	N	P		
Tenex (guanfacine)	N	P		
Wellbutrin (bupropion)	N	P		
Prozac (fluoxetine)	N	P		
Zoloft (sertraline)	N	P		
Celexa (citalopram)	N	P		
Lexapro (escitalopram)	N	P		
Luvox (Fluvoxamine)	N	P		
Paxil (paroxetine)	N	P		
Effexor (venlafaxine)	N	P		
Cymbalta (duloxetine)	N	P		
Remeron (mirtazepine)	N	P		
Trazodone	N	P		
Depakote (divalproex)	N	P		
Trileptal (oxcarbazepine)	N	P		
Tegretol (carbamazepine)	N	P		
Lamictal (lamotrigine)	N	P		
Lithium	N	P		
Risperdal (risperidone)	N	P		
Zyprexa (olanzapine)	N	P		
Seroquel (quetiapine)	N	P		
Abilify (aripiprazole)	N	P		
Invega (paliperidone)	N	P		
Geodon (ziprasidone)	N	P		
Others (Specify)	N	P		
	N	P		
	N	P		
	N	P		

Please write any additional information about medication treatments below:

Behaviors and Symptoms

Hits or punches others when angry	Never	Past	Sometimes	Often	Always
Threatens to hurt or kill others	Never	Past	Sometimes	Often	Always
Hurts self (cutting, head-banging)	Never	Past	Sometimes	Often	Always
Threatens suicide	Never	Past	Sometimes	Often	Always
Has attempted suicide	Never	Past	Sometimes	Often	Always
Stays out all night	Never	Past	Sometimes	Often	Always

Your notes regarding dangerous behaviors:

Defiant of adults at school/talks back	Never	Past	Sometimes	Often	Always
Defiant of adults at home/talks back	Never	Past	Sometimes	Often	Always
Argues with adults	Never	Past	Sometimes	Often	Always
Refuses to do what he/she is told by adults	Never	Past	Sometimes	Often	Always
Easily frustrated	Never	Past	Sometimes	Often	Always
Angry or resentful	Never	Past	Sometimes	Often	Always
Spiteful or vindictive	Never	Past	Sometimes	Often	Always
Annoys others deliberately	Never	Past	Sometimes	Often	Always
Blames others for his/her mistakes	Never	Past	Sometimes	Often	Always

Your notes regarding defiant and disruptive behaviors:

Trouble listening to directions/following through	Never	Past	Sometimes	Often	Always
Disorganized	Never	Past	Sometimes	Often	Always
Easily distracted from tasks	Never	Past	Sometimes	Often	Always
Loses things necessary for task completion	Never	Past	Sometimes	Often	Always
Trouble focusing to complete tasks	Never	Past	Sometimes	Often	Always
Forgetful	Never	Past	Sometimes	Often	Always
Driven or hyperactive	Never	Past	Sometimes	Often	Always
Fidgety/squirmy	Never	Past	Sometimes	Often	Always
Trouble staying seated	Never	Past	Sometimes	Often	Always
Too loud/talks too much	Never	Past	Sometimes	Often	Always
Trouble taking turns, waiting	Never	Past	Sometimes	Often	Always
Interrupts, butts in	Never	Past	Sometimes	Often	Always
Blurts answers before hearing the whole question	Never	Past	Sometimes	Often	Always

Your notes regarding problems with focus, concentration, and impulse control:

Seems sad	Never	Past	Sometimes	Often	Always
Talks of death	Never	Past	Sometimes	Often	Always
Can't seem to have fun, losing interests	Never	Past	Sometimes	Often	Always
Cries	Never	Past	Sometimes	Often	Always
Talks of feeling guilty	Never	Past	Sometimes	Often	Always
Talks of feeling worthless	Never	Past	Sometimes	Often	Always
Talks of being hopeless that things will improve	Never	Past	Sometimes	Often	Always
Talks of feeling helpless to make things better	Never	Past	Sometimes	Often	Always
Listless, lacking energy	Never	Past	Sometimes	Often	Always
Lacking motivation	Never	Past	Sometimes	Often	Always
Sick, tired, achy, physical complaints	Never	Past	Sometimes	Often	Always
Can't fall asleep	Never	Past	Sometimes	Often	Always
Can't stay asleep	Never	Past	Sometimes	Often	Always
Sleeps too much	Never	Past	Sometimes	Often	Always
Eats too little (losing weight)	Never	Past	Sometimes	Often	Always
Eats too much (gaining weight)	Never	Past	Sometimes	Often	Always
Excessive/distorted concern about body weight	Never	Past	Sometimes	Often	Always
Binge eating	Never	Past	Sometimes	Often	Always
Vomiting or using laxatives to lose weight	Never	Past	Sometimes	Often	Always
Starvation diets or excessive exercise	Never	Past	Sometimes	Often	Always
Other depressive behaviors: (specify)	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

Your notes regarding depressive behaviors:

Odd or unusual bursts of energy	Never	Past	Sometimes	Often	Always
Shouts at others and starts fights	Never	Past	Sometimes	Often	Always
Unusually self-confident and socially outgoing	Never	Past	Sometimes	Often	Always
Able to get by on a lot less sleep than usual	Never	Past	Sometimes	Often	Always
Much more talkative than usual	Never	Past	Sometimes	Often	Always
Unusual pressure to speak (rushing words)	Never	Past	Sometimes	Often	Always
Unusually distracted by things around him/her	Never	Past	Sometimes	Often	Always
Trouble concentrating	Never	Past	Sometimes	Often	Always
Eager to take on many more projects than usual	Never	Past	Sometimes	Often	Always
Unusually/excessively interested in sex	Never	Past	Sometimes	Often	Always
Does things that are extremely foolish or risky	Never	Past	Sometimes	Often	Always
Spends excessive amounts of money	Never	Past	Sometimes	Often	Always
Other odd mood shifts (specify)	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

Your notes regarding mood instability and agitation

Excessive worries or fears	Never	Past	Sometimes	Often	Always
Difficulty separating from familiar people	Never	Past	Sometimes	Often	Always
Panic attacks	Never	Past	Sometimes	Often	Always
Trouble leaving home	Never	Past	Sometimes	Often	Always
Checking rituals	Never	Past	Sometimes	Often	Always
Counting rituals	Never	Past	Sometimes	Often	Always
Washing rituals	Never	Past	Sometimes	Often	Always
Disturbing thoughts that won't go away	Never	Past	Sometimes	Often	Always
Panicked around unfamiliar people	Never	Past	Sometimes	Often	Always
Physical symptoms when upset	Never	Past	Sometimes	Often	Always
Excessive worry about illnesses	Never	Past	Sometimes	Often	Always
Too nervous to face going to school	Never	Past	Sometimes	Often	Always
Nightmares	Never	Past	Sometimes	Often	Always
On the look-out for dangers	Never	Past	Sometimes	Often	Always
Other anxieties (specify)	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

Your notes regarding anxieties:

Hears voices that no one else hears	Never	Past	Sometimes	Often	Always
Sees visions	Never	Past	Sometimes	Often	Always
Has odd ideas or beliefs that couldn't be true	Never	Past	Sometimes	Often	Always
Believes imaginary friends are real	Never	Past	Sometimes	Often	Always
Behaves in a way that others consider odd	Never	Past	Sometimes	Often	Always
Gradual neglect of hygiene	Never	Past	Sometimes	Often	Always
Other strange or bizarre behaviors (specify)	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

Your notes regarding psychosis or other odd/unusual behaviors

Thank you for completing this questionnaire. If you have reports, or checklists from school, please provide copies that can be left with the doctor for later review. Attach extra pages with your notes and observations if you wish.