

BEHAVIORAL HEALTH & DEVELOPMENTAL SCREENING FORM

CHILD'S NAME:	_____	(LAST)	(FIRST)	(MIDDLE)
MEDICAID ID #:	_____	SEX:	M: _____ F: _____	DATE OF BIRTH: ____/____/____

SECTION A: BEHAVIORAL HEALTH RISK FACTORS: (Please refer to the attached *SCREENING FORM GUIDELINES* for an expanded discussion of risk factors. Your own professional judgment will determine whether you should refer for a behavioral health assessment based on the presence of one or more indicators. In all instances, however, when you believe any of the following three factors is present, you should refer for an assessment.)

- Child's history includes incident(s) of severe neglect or physical, emotional or sexual abuse.
- Child's behavioral history includes incident(s) of self-destructive or aggressively violent behavior.
- Family history includes severe emotional, behavioral, or neurobiological disorder or severe mental illness.

SECTION B: BEHAVIORAL HEALTH SCREENING:

Behavioral Indicators	Yes	No
1. Use of alcohol or other drugs		
2. Parents or friends abuse alcohol or use other drugs		
3. Serious emotional or behavioral problems in school		
4. Sets fires		
5. Intentional cruelty to animals		
6. Seriously injures or threatens to seriously injure others		
7. Perpetrates sexual abuse		
8. Talks about hurting self or hurts self		
9. Withdrawn or depressed		
10. Attempted suicide		
11. Hyperactive or agitated		
12. Has sleeping or eating problems		
13. Purposely destroys things		
14. Has hallucinations or delusions		
15. Other unusual behaviors		
16. Other emotional or behavioral problem that concerns the parent		

SECTION C: DEVELOPMENTAL SERVICES SCREENING:

To be answered by medical professional administering screening:	Yes	No	To be asked of the parent/guardian:	Yes	No
1. Does the screening reveal the existence of delayed development, mental retardation, cerebral palsy, spina bifida, autism or Prader Willi Syndrome?			5. Does your infant/child seem socially withdrawn or have difficulty communicating?		
2. Does the screening reveal the child is at risk of a later diagnosis of cerebral palsy, mental retardation, autism or Prader Willi Syndrome?			6. Is your infant/child extremely resistant to change in daily routine or sleeps less than 5 hours/ night?		
3. Is there evidence that the primary caregiver has a developmental disability?			7. Is your child in special education classes in school?		
4. Are you or your child's physician concerned about your child's development?			8. Does your child receive SSI because of a developmental disability?		

NOTE: If "yes" to questions 1-8 above, refer the child to Children's Medical Services ages birth to 3, Developmental Services if greater than 3 years old.

<p style="text-align: center;">OUTCOME OF SCREENING:</p> <p><input type="checkbox"/> No referral is needed</p> <p><input type="checkbox"/> Referral is needed, and parent/guardian consents</p> <p><input type="checkbox"/> Referral is needed, but parent/guardian declines</p> <p>Referral made for:</p> <p><input type="checkbox"/> Mental Health Assessment</p> <p><input type="checkbox"/> Substance Abuse Assessment</p> <p><input type="checkbox"/> Children's Medical Services Assessment (0-3)</p> <p><input type="checkbox"/> Developmental Services Assessment (3-21)</p>	<p style="text-align: center;">REFERRAL FOR ASSESSMENT:</p> <p><input type="checkbox"/> Referral made on: ____/____/____</p> <p><input type="checkbox"/> Referral made to: _____</p> <p style="text-align: right;">(Agency name)</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">(Agency address)</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">(Agency phone number)</p>		
(Signature/title of screener) _____	(Date of screening) _____	(Signature/title of person referring) _____	(Date) _____