



## 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 \_\_\_\_\_ which included the following as required by  
 A.R.S. § 8-271(5) and A.R.S. § 8-272(B):  
*Date*

#### **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*



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