Child and Adolescent Mental Health Service

CHILDRENS LEARNING DISABILITY TEAM

**INITIAL ASSESSMENT**

**Patient**

|  |  |
| --- | --- |
| Name: | Click or TAB to enter Name |
| Middle Name: | Middle Name |
| Surname: | Surname |
| Preferred Name: | Preferred Name |
| Date of Birth: | Date of Birth |
| Home Tel Number: | Home Telephone Number |
| Address: | Address |
|  |
| Postcode: | Postcode |

|  |  |
| --- | --- |
| First Language: | First Language |
| Gender: | Male  Female |
| Religion: | Religion |
| Lives with: | Lives with… |
| Ethnic Origin: | Ethnic Origin |
| Country of Origin: | Country of Origin |
| Place of Birth: | Place of Birth |
| Interpreter Required: | Yes  No |
| Language: | Language |

**Parent/Carer/Foster Parents**

|  |  |
| --- | --- |
| Title: | Click or TAB to enter Title |
| Name: | Name |
| Surname: | Surname |
| Address: | Address |
|  |
| Postcode: | Postcode |

|  |  |  |
| --- | --- | --- |
| Relationship to Child: | Relationship to Child | |
| First Language: | First Language | |
| Home Tel Number: | Home Telephone Number | |
| Mobile Tel Number: | Mobile Telephone Number | |
| Work Tel Number: | Work Telephone Number | |
| Regular contact with parent: | | Yes  No |

**Parent/Carer/Foster Parents**

|  |  |
| --- | --- |
| Title: | Click or TAB to enter Title |
| Name: | Name |
| Surname: | Surname |
| Address: | Address |
|  |
| Postcode: | Postcode |

|  |  |  |
| --- | --- | --- |
| Relationship to Child: | Relationship to Child | |
| First Language: | First Language | |
| Home Tel Number: | Home Telephone Number | |
| Mobile Tel Number: | Mobile Telephone Number | |
| Work Tel Number: | Work Telephone Number | |
| Regular contact with parent: | | Yes  No |

**Parental Responsibility**

|  |  |
| --- | --- |
| Mother: | Yes  No |
| Father: | Yes  No |

|  |  |
| --- | --- |
| Other: | Please state who |

**GP Details**

|  |  |
| --- | --- |
| GP: | GP Name |
| Address: | Address |
|  |
| Postcode: | Postcode |
| Tel Number: | Telephone Number |

**School Details**

|  |  |  |  |
| --- | --- | --- | --- |
| School: | | School Name | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Teacher: | | Teacher Name | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/reports to be sent: | | | Yes  No |
| Signature: |  | | |

**Social Services**

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Name: | | Name | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**Paediatrician/Other Consultant**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | Name | |
| Clinic Location: | | Location | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**Respite Care**

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Name: | | Name | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**Any Other Professional Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | Name | |
| Clinic Location: | | Location | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**Any Additional Relevant Information/Risks etc.**

|  |  |
| --- | --- |
| Child Protection Concerns: | Yes  No |

|  |  |  |
| --- | --- | --- |
| On CP Register: | | Yes  No |
| Category: | Category | |

**Further Details**

|  |
| --- |
| Further details… |

**Other Agencies Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | Name | |
| Agency: | | Agency | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**Other Agencies Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | Name | |
| Agency: | | Agency | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**Other Agencies Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | Name | |
| Agency: | | Agency | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**Other Agencies Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | Name | |
| Agency: | | Agency | |
| Address: | | Address | |
|  | |
| Postcode: | | Postcode | |
| Tel Number: | | Telephone Number | |
| Permission to share information: | | | Yes  No |
| Copies of clinic letters/report to be sent: | | | Yes  No |
| Signature: |  | | |

**REFERRAL**

|  |  |  |
| --- | --- | --- |
| DATE RECEIVED: | RECEIVED BY: | REFERRED BY: |
| Enter date received | Referral received by… | Referral made by... |
| WHAT PROBLEMS DOES THE REFERRER STATE AND WHAT ARE THEIR EXPECTATIONS? | | |
|  | | |
| WHAT PROBLEMS DOES THE CLIENT’S CARER IDENTIFY AND WHAT ARE THEIR EXPECTATIONS OF THE APPOINTMENT? | | |
|  | | |
| WHAT PROBLEMS DOES THE CLIENT IDENTIFY AND WHAT DOES HE/SHE WANT? | | |
|  | | |

**Professional Completing Initial Assessment**

|  |  |  |
| --- | --- | --- |
| FORMS COMPLETED BY:  (name and sign) | DISCIPLINE/DESIGNATION: | DATE(S): |
| Professor Frank M C Besag  FRCP FRCPsych FRCPCH | Consultant Neuropsychiatrist |  |
| SOURCES OF INFORMATION: | | |
|  | | |

**Family Structure**

|  |
| --- |
|  |

**Family Medical History**

|  |
| --- |
|  |

**Developmental History**

|  |
| --- |
| Pregnancy |
|  |
| Delivery |
|  |
| Neonatal Period |
|  |
| Milestones |
|  |
| History of Autistic Features |
|  |

**Past Medical History**

|  |
| --- |
|  |

**Seizure History**

|  |
| --- |
|  |

**Medication History and Current Regime**

|  |
| --- |
|  |

**Schooling History**

|  |
| --- |
|  |

**Current Status**

|  |
| --- |
| Personality |
|  |
| Behaviour |
|  |
| Mobility |
|  |
| Communication |
|  |
| Dressing |
|  |
| Sleep |
|  |
| Eating |
|  |
| Bowels and Bladder |
|  |
| Relationships |
|  |
| Independence Skills |
|  |
| Awareness of Danger |
|  |
| Sexual Maturity |
|  |
| Literacy and Numeracy |
|  |
| Occupation |
|  |

**Weekly Timetable of Events**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Morning | Afternoon | Evening |
| Monday |  |  |  |
| Tuesday |  |  |  |
| Wednesday |  |  |  |
| Thursday |  |  |  |
| Friday |  |  |  |
| Saturday |  |  |  |
| Sunday |  |  |  |

**Family Support Networks**

|  |
| --- |
|  |

**Current Problems**

|  |
| --- |
|  |

**Interview with the child on their own**

|  |
| --- |
|  |

**On Examination**

|  |
| --- |
| Cardiovascular System |
|  |
| Respiratory System |
|  |
| Alimentary System |
|  |
| Nervous System |
|  |
| Head Circumference |
|  |

**Summary**

|  |
| --- |
|  |

**Future action and recommendations**

|  |
| --- |
|  |