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REGIONAL PSYCHIATRIC EMERGENCY SERVICES FOR CHILDREN AND YOUTH

MENTAL HEALTH ASSESSMENT
Short Form
Crisis Intervention

Date of Assessment:_____ **Time of assessment:**_____

Referred by: Select **Notes:** _____

Reason for referral / Main Concerns:

- ☐ Depression
- ☐ Anxiety
- ☐ Psychosis
- ☐ Behaviour Problems
- ☐ Development Delay
- ☐ Suicidal ideation
- ☐ Suicide Attempt / Gesture
- ☐ Self Injurious Behaviour
- ☐ Homicidal ideation
- ☐ Psychosocial Crisis / Family Conflicts
- ☐ Psychological Trauma
- ☐ Form 1
- ☐ Form 2
- ☐ Section 17
- ☐ Other: _____

Living with: **Legal Guardian:**

Custody Issues:

CAS involved? **Status:**

Presenting Concerns / Stressors:

Mental Health Review:

Sleep:

Interests:

Guilt:

Energy:

Concentration:

Appetite:

Psycho-motor

Meds:

Allergies:

Additional Information:

Suicide Risk: Select

Plan / Recommendations:

Discussed with Psychiatrist on-call? Select Dr.

Signature: _____