

# Sample RBHS Initial Diagnostic Assessment

---

**School District:** \_\_\_\_\_

**Student Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Medicaid#** \_\_\_\_\_ **Procedure Code:** \_\_\_\_\_

**Date of Admission:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**School:** \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

**Address:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Number Street City Zip code

**Phone:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Employer:** \_\_\_\_\_

**Name of other parent or guardian:** \_\_\_\_\_

**Address:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Number Street City Zip code

**Phone:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Employer:** \_\_\_\_\_

**In case of emergency contact:**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Name of Primary Care Physician:** \_\_\_\_\_

**Student Assessment:**

# Sample RBHS Initial Diagnostic Assessment

---

**Siblings and others in household:**

**Presenting complaint (reason for assessment):**

**Symptoms:**

.

**Medical history and medications:**

# Sample RBHS Initial Diagnostic Assessment

---

**Pertinent family history:**

**Psychological and/or psychiatric treatment history for student:**

**Relevant educational records/tests:**

# Sample RBHS Initial Diagnostic Assessment

---

**Substance use history for student:**

**Mental status:**

**Summary of information from testing:**

# Sample RBHS Initial Diagnostic Assessment

---

**Functional Assessment (with age appropriate expectations):**

**Exposure to physical abuse, sexual abuse, antisocial behavior, other traumatic events:**

# Sample RBHS Initial Diagnostic Assessment

---

**Current edition DSM and ICD diagnosis:**

**Treatment recommendation, if appropriate:**

*(Describe or list the type of services and why the services are medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Provider's medical records on each beneficiary must substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.)*

**CALOCUS results, if administered:**

# Sample RBHS Initial Diagnostic Assessment

---

## **Parental/ Family Assessment:**

**Psychological and/or psychiatric treatment history for family:**

# Sample RBHS Initial Diagnostic Assessment

---

**Substance use history for family:**

**Other Comments:**

Provider Name \_\_\_\_\_ Title \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

9/10/14