Division of Youth Services

REQUEST FOR QMHP CONSULTATION (XIII.3.F)

Student Name: DOB:

Cottage/POD: Risk Level Score:

Commitment Date: Commitment Number:

Community Counselor: County:

OTS Counselor:

Committing Offense:

To Be Completed by the OTS Counselor

Reason for Referral: problem area specified as evidenced by the following behavior(s) occurring during the last day(s).

Problem Behavior(s):

Requested Consultation: service specified.

____ Date/Time of Request:
Signature of OTS Staff Member

Intake, Evaluation and Referral Process

To Be Completed by the Clinical Administrator

Action on Consultation Request: action specified Comments:

____ Date/Time of Action:
Signature of Clinical Administrator

Tracking (Quality Assurance)

QMHP:__________________________ Date/Time Assigned:

Division of Youth Services

QMHP CONSULTATION REPORT

Student Name: DOB:

Cottage/POD: Risk Level Score:

Commitment Date: Commitment Number:

Community Counselor: County:

OTS Counselor:

Committing Offense:

Consultation Report

To Be Completed by the Consultant:

Records Reviewed:

Identifying Information: .

Findings: .

Initial Diagnosis:

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: GAF Current GAF Highest

Comments: .

Recommendations: .

____ Date/Time of Action:
Signature of Consultant