



HEALTHY KIDS
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)
REFERRAL FOR MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

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|--|--|---|--------------------------------------|----------------------|
| SECTION I. PATIENT INFORMATION | | | | |
| 1. PATIENT'S NAME | | 2. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female | 3. PATIENT IDENTIFICATION CODE (PIC) | 4. BIRTH DATE |
| 5. RACE | 6. PARENT'S/GUARDIAN'S NAME | | 7. RELATIONSHIP TO PATIENT | 8. TELEPHONE NUMBER |
| 9. STREET ADDRESS | | CITY | STATE | ZIP CODE |
| SECTION II. PRIMARY CARE PROVIDER INFORMATION | | | | |
| 1. PRIMARY CARE PROVIDER'S NAME | | 2. TELEPHONE NUMBER | | 3. DATE OF SCREENING |
| 4. STREET ADDRESS | | CITY | STATE | ZIP CODE |
| 5. LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING | | 6. LIST PHYSICAL CAUSES THAT WERE RULED OUT | | |
| 7. DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED | | | | |
| 8. REFERRAL TYPE <input type="checkbox"/> Regular <input type="checkbox"/> Urgent | 9. REFERRED TO: <input type="checkbox"/> Mental Health Assessor <input type="checkbox"/> Substance Abuse Assessor <input type="checkbox"/> Regional Support Network | | | |
| 10. REASON FOR REFERRAL | | | | |
| 11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE | | | | DATE |
| SECTION III. PATIENT INTERPRETATION CERTIFICATION | | | | |
| I certify that the above referral was explained to _____ PATIENT OR PARENT/GUARDIAN | | | | |
| in _____ LANGUAGE and executed in my presence. | | | | |
| WITNESS/INTERPRETER'S SIGNATURE | | | | DATE |
| SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE | | | | |
| 1. ASSESSMENT RECEIVED <input type="checkbox"/> Mental health <input type="checkbox"/> None; explain: <input type="checkbox"/> Substance abuse | | | | |
| 2. INITIAL TREATMENT PLAN | | | | |
| 3. EXPLAIN WHY IF NO SERVICES ARE NEEDED | | | | |
| 4. ASSESSOR'S NAME | | DATE | | 5. TELEPHONE NUMBER |



Missouri State
Department of Social
& Health Services

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INSTRUCTIONS

SECTION I. PATIENT INFORMATION

1. **PATIENT'S NAME:** The name of the patient being screened.
2. **SEX:** The sex of the patient being screened.
3. **PATIENT IDENTIFICATION CODE (PIC):** The state-assigned PIC number printed on the medical coupon.
4. **BIRTH DATE:** The birth date (month/day/year) of the patient being screened.
5. **RACE:** The patient's race.
6. **PARENT'S/GUARDIAN'S NAME:** The name of the patient's parent or legal guardian, if the patient is under 18 years of age.
7. **RELATIONSHIP TO PATIENT:** Mother, father, grandmother, legal guardian, etc.
8. **TELEPHONE NUMBER:** The telephone number of the patient, or parent/guardian if the patient is not the responsible party for authorizing the mental health and/or drug/alcohol referral and exchange of medical information.
9. **STREET ADDRESS, CITY, STATE, AND ZIP CODE:** The full address of the patient, or parent/guardian if the patient is not the responsible party for authorizing the mental health and/or drug/alcohol referral and exchange of medical information.

SECTION II. PRIMARY CARE PROVIDER INFORMATION

1. **PRIMARY CARE PROVIDER'S NAME:** The name of the primary care provider.
2. **TELEPHONE NUMBER:** The telephone number of the primary care provider.
3. **DATE OF SCREENING:** The date (month/day/year) the Healthy Kids/EPST screen was done.
4. **STREET ADDRESS, CITY, STATE, AND ZIP CODE:** The full address of the primary care provider.
5. **LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING:** List the medication you are aware that the patient is taking, including prescription, over-the-counter, and illegal drugs.
6. **LIST PHYSICAL CAUSES THAT WERE RULED OUT:** List the physical causes that were ruled out that could cause or aggravate the mental health and/or drug/alcohol symptoms that are being exhibited or suspected.
7. **DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED:** Describe any known previous mental health/substance abuse services that the patient has already received.
8. **REFERRAL TYPE:** Indicate whether this is a regular or urgent referral.
REGULAR REFERRAL - A regular referral is indicated if, in your professional **judgment**, behaviors are present that need assessing such as: alcohol/substance abuse; family conflict; troubled peer relationships; school failure; somatic symptoms, abnormal behaviors, feelings, or thoughts; growth and development deficits; or social situation problems.
URGENT REFERRAL - An urgent referral may be indicated if any of the following behaviors are present: victimization (untreated behaviors still evident); witness to death/substantial physical violence; at imminent risk of placement in restrictive setting; delusional, out of touch with reality; self-destructive behavior; destroying property; torturing animals; fire setting; sexually acting out; and suicidal behavior/ideation. Please contact the mental health provider, alcohol/substance abuse provider, or crisis response services immediately as appropriate.
9. **REFERRED TO:** Indicate where referred - mental health assessor, substance abuse assessor, and/or Regional Support Network.
10. **REASON FOR REFERRAL:** Describe the reason this patient is being referred for a mental health or alcohol/substance abuse assessment.
11. **PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE:** The signature of the medical provider performing the Healthy Kids/EPST medical screen. This may be a physician, Advance Registered Nurse Practitioner, or Physician's Assistant.

SECTION III. PATIENT INTERPRETATION CERTIFICATION

The language interpreter that explained this form and its' purpose to the patient or parent/guardian should fill in the patient or parent/guardian's name and in what language. This should be certified by the signature of the interpreter, and should be dated (month/day/year).

SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE

1. **ASSESSMENT RECEIVED:** Indicate if a mental health or substance abuse assessment or no assessment was received by the patient. If no assessment was received, explain why.
2. **INITIAL TREATMENT PLAN:** Summarize the initial treatment plan of mental health and/or alcohol/substance abuse services you recommend the patient should receive.
3. **EXPLAIN WHY IF NO SERVICES FOR THE PATIENT ARE NEEDED:** If no mental health and/or alcohol/substance abuse services are recommended, explain why.
4. **ASSESSOR'S NAME, DATE:** Sign the mental health or alcohol/substance assessor's name and date of the assessment.
5. **TELEPHONE NUMBER:** The telephone number of the mental health or alcohol/substance abuse assessor.