

*Circles of Care*

**Psychiatric/Psychological Service Report**

(Report/form is not for routine counseling sessions)

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Date of Visit

DOB: \_\_\_\_\_ Adult/caregiver name: \_\_\_\_\_

***Type of appointment-***  
*(Check One)*

Initial:  Follow-up/routine Visit:  Emergency:  Other: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Result of Visit, Diagnosis and Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Axis I: \_\_\_\_\_ Axis IV: \_\_\_\_\_

Axis II: \_\_\_\_\_ Axis V: GAF \_\_\_\_\_

Axis III: \_\_\_\_\_

**Medication Prescribed:**

<u>in</u> <u>Name</u>	Check if *		Check if this is a change
	<u>New Medication</u>	<u>Dosage/administration</u>	<u>dosage/administration from</u> <u>previously</u>
	<u>prescribed</u> *		

Please give a "range of time" administration, if medically appropriate, to account for school days vs. weekends and holidays.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\*Must be approved by TDPRS before new administration begins

**Medications Discontinued this appointment:**

**Name of medication(s)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Next visit scheduled for:  30 days  60 days  Other: Give  
specifics: \_\_\_\_\_

\_\_\_\_\_  
Doctors Name (please print)

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Consulting Doctors Name (please print)

\_\_\_\_\_  
Signature of Doctor

Address and phone number: \_\_\_\_\_

**Medical Plan of Treatment for Psychotropic Medications:**

**Only complete this page for new medications prescribed.**

Medications Continued, no changes in initial plan.

**Expected benefits of medication:**

---

---

---

**Possible risks or adverse consequences of not using/taking medications:**

---

---

---

**Side effects or adverse effects of medication:**

---

---

---

**Special precautions:**

---

---

**Potential interactions of different medications:**

---

---

**Recommended test(s) or monitoring of medications:**

---

---

**Plan for reduction of medications:**

---

---

---

**Office Use Only**

**Date FP turned in:** \_\_\_\_\_ **Date sent/contact to TDPRS for approval:** \_\_\_\_\_ **Approved by/date:** \_\_\_\_\_