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: ______________________________________

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____

Axis I:____ **Axis IV:**__________________________

Axis II:_______________________________________ **Axis V: GAF** ____________________

Axis III:_______________________________________

Medication Prescribed:

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

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:

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____

Special precautions:

____

____

Potential interactions of different medications:

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____

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:**______________________