DPP-106G
(R. 11/11)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services
MENTAL HEALTH SERVICES

CHILD'S NAME: _____ DOB: _____

THERAPIST / COUNSELOR: _____ Phone: _____

PSYCHIATRIST / PHYSICIAN: _____ Phone: _____

COUNSELING / THERAPY SESSION Date: _____

Current frequency of appointments: Weekly: ☐ Twice Weekly: ☐ Other: _____

Please rate the child's progress in meeting all goals on the following scale.

(Has Work To Do) 1 2 3 4 5 6 7 8 9 10 (Work Completed Successfully)

Current Psychiatric Medication. If none, please indicate with a check here ☐

Diagnosis	Medication if needed	Dosage

A conference session with one or more of the individual(s) circled below is needed. ***Please call to schedule.***

Birth Parent Care Provider Family Services Worker Sibling Psychiatrist Other: _____

Homework Assignment: _____

Notes / Comments: _____

_____

Therapist / Counselor Signature: _____ Next Appointment: _____

MEDICATION MANAGEMENT APPOINTMENT Date: _____

Height: _____ Weight: _____ Blood Pressure: _____

Diagnosis	Medication	Dosage

Referral for Testing / Evaluation Needed (Please indicate Blood Work, MRI, CT Scan, Other): _____

_____

Please Note: Birth parents and the family social service worker are to be notified of any change in medications. This includes dosage, stopping a medication or starting a new medication. If possible, make this notification **prior to** the change in medication.

Physician Signature: _____ Next Appointment: _____

File: Original in Passport Folder
Copy in Professional