

Western Highlands Network Child Utilization Review Worksheet Initial Request

To accompany a SAR for Intensive In-Home, Multisystemic Therapy, Day Treatment. **All sections of the form need to be completed. Incomplete/unsigned forms will result in a pended SAR.**

Date: _____ WHN Client # _____

Client name: _____ DOB: _____

DIAGNOSIS:

Axis Ia: _____	Axis Ib: _____	IPRS Target Pop _____
Axis IIa: _____	Axis IIb: _____	
Axis III: _____	Additional: _____	LOC: A B C D

Service Requested: _____

Current Services: _____

Treatment and Out-Of-Home Placement History:

- 1)
- 2)
- 3)
- 4)
- 5)

of Previous Hospitalizations: _____ Date of most recent hospitalization: _____
 Current Legal Charges/Convictions: _____ # of ES calls during the last 90 days: _____
 Has the client been assessed for medication? Y N If not, why? _____

Date of last psychiatric evaluation: _____ Date of last med check: _____
 Date of last psychological evaluation: _____ Date of last Substance Abuse evaluation: _____
 Date of last Sex Offender Specific Evaluation: _____
 What other options considered? _____
 Why were these options ruled out? _____

General Description of client situation and need: (precipitating events, behaviors and symptoms leading to the decision to seek requested service)

Child & Family Team Review

Please circle those who had input in requesting this service: Family DSS DJJ School Supervisor
 Family Doctor Therapist Psychiatrist/NP Other Community Agency Guardian
 Other(s): _____

What is the step down/discharge plan for this requested service? _____

Is service/placement request clinically appropriate? Y N

Case Responsible Staff /Date

Supervisor/Date