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|  | **ECLIPSE** **Initial Assessment** |

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| CONTRACTED PROVIDER | ECLIPSE SITE |
|  ADDRESS | CITY | STATE | ZIP CODE |
| CONTACT PERSON | TELEPHONE NUMBER |
| REFERRING AGENCY**[ ]**  Child Welfare **[ ]**  Public Health Nurse **[ ]**  Economic Services Administration **[ ]**  Primary Care Physician |
| CHILD’S NAME | DATE OF BIRTH | AGE |
| DATE OF ADMISSION | EPSDT DATE | CHILD ID NUMBER |
| **ASSESSMENT DATES** |
| PARENT - CHILD OBSERVATION | FAMILY ASSESSMENT | CLINICIAN OBSERVATION |
| CLINICIAN OBSERVATION | CLINICIAN OBSERVATION | DEVELOPMENTAL ASSESSMENT |
| **DIAGNOSES AND TOOLS USED TO DETERMINE THE ASSIGNED DIAGNOSES** |
| **Diagnostic Classification of Mental Health and Developmental Disorders of Infancy Early Childhood: Revised Edition (DC: 0-5) (birth to 60 months)**5 AXIS DIAGNOSTIC CODEAXIS I Clinical Disorder **Level of Acuity (Check Level)- Mild** **[ ]  Moderate [ ]  Serious [ ]  Severe [ ]** AXIS II Relational Context 1. Caregiving Relationship
2. Caregiving Environment

AXIS III Physical Health Conditions and ConsiderationsAXIS IV Psychosocial Stressors AXIS V Developmental Competence * Emotional

 - Social-Relational - Language-Social/Communication - Cognitive - Movement and Physical  |

**Describe symptoms that qualify child to attend program as per medical necessity. Medical Necessity is satisfied on Axis** **based on the following:**

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| **Please provide narrative of the parent child observations and family assessment:** |

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| **Describe Case History: Was there a traumatic event prior to initial symptoms; symptom onset/duration; pervasiveness:** |

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| **Developmental Competence:** |

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| **Child Safety Issues:** |

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| **Participation:Parental** |

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| **Anticipated Outcomes** |

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| **Anticipated Duration of Treatment:** |

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| **ECLIPSE CERTIFICATION AND SIGNATURES** |
| By signing below, I certify all the information I have provided concerning this child is correct and accurately reflects that ECLIPSE mental health services are medically necessary to treat psychosocial disorders of this child. |
| LICENSED PRACTITIONER NAME/LICENSE # | LICENSED PRACTITIONER TITLE |
| LICENSED PRACTITIONER SIGNATURE | DATE |
| **PARENT/GUARDIAN SIGNATURE(S) WAC388-877A-0120(6)** |
| By signing below, I certify that I was provided with information and education regarding child’s diagnosis.  |
| PARENT/GUARDIAN SIGNATURE DATE  |
| PARENT/GUARDIAN SIGNATURE DATE |