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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 CODE  AXIS 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 Considerations  AXIS 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 | | |