

Clinical Summary Template

The Children's System of Care will utilize the Clinical Summary Template to assist in the determination of an appropriate intensity of service for any of the following reasons:

1. Linkage with CSOC Care Management Services
2. A supplemental document for Care Management-linked youth, who are currently receiving community-based therapeutic services, and are being referred for OOH treatment.
3. Potential linkage to other CSOC services

Please Note #1: If a youth is participating in the Community Care Waiver through the Division of Developmental Disabilities, the youth is not eligible for CSOC services. Please do not use this document.

Please Note #2: If a youth is in need of Substance Use Treatment services, please refer to the PerformCare Website, at www.performcarenj.org, for instructions on how to access services. Please do not use this document.

The Clinical Summary Template is to be completed by an independently licensed clinician (i.e. LCSW, LPC, MD, Ph.D., Psy.D) who is currently providing treatment services to the youth and is informed about the youth's current strengths and needs. All fields are mandatory and must be typed. Download the form to complete, then fax to **1-877-736-9166**.

If you need additional information regarding the clinical summary template, or referring a child for CSOC services, please contact PerformCare at **1-877-652-7624** for assistance.

Clinical Summary Template

Date:	Assessor Name:	Credentials:
Assessor's Agency:		Phone Number:
Email Address:		
Mailing Address:		

Youth's Name:	DOB:
Gender:	Race/Ethnicity:
CYBER ID#	
<i>If the youth has not had services through the Children's System Of Care, please instruct the legal guardian to call 877-652-7624 to register the youth.</i>	

Parent/Legal Guardian's Name:		
Guardianship Status (i.e. DCP&P Custody or Guardianship):		
Address:		
City:	State:	Zip:
Primary Phone:		Secondary Phone:
Youth's Current Address (if different from above):		
Primary language spoken in the home:		

Reason for Submission of the Clinical Summary Template:

(i.e. presenting needs, risk of out of home placement, multisystem involvement, current functional status)

Current Status/Treatment & Youth System Involvement:

Behavioral Health (include Outpatient, Intensive In-Home, Partial Hospitalization/ Partial Care Programs, Out of Home, Inpatient Hospitalizations):

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Substance Use (include type of substance, pattern of use, age of onset, types of treatment - Outpatient, Intensive Outpatient, Partial Hospitalization Programs, Short Term Residential, Long Term Residential, Detoxification, Inpatient hospitalizations):

Physical Health/ Medical (include active Issues):

Child Welfare/DCP&P (include history of abuse or neglect and descriptions including duration, perpetrator; services including in home services, resource/foster home, therapeutic treatment home):

DD Eligibility Status (include describing any functional challenges or limitations):

Juvenile Justice (include case pending, FCIU, probation, detention, day program, DAP, incarceration, parole):

Specialty Needs (include fire setting, problematic sexual behavior, cruelty to animals, and assaultive behaviors, which has occurred in the past 2 year period – also include details in regards to the severity and frequency of these behaviors and timeline with most recent occurrence):

School (include type of school placement, i.e. regular education, special education, in district/out of district, home instruction):

Contact information for DCP&P case worker and supervisors, if involved:	
DCP&P Case Worker:	Phone:
DCP&P Supervisor:	Phone:

Current court orders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Specify:		

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Current Presenting Behavioral Symptoms:

Youth Behavioral/Emotional Needs (please check any behaviors that are relevant to the treatment needs of the youth and/or exhibited in the last 30 days):

<input type="checkbox"/>	Psychosis (Hallucinations, delusional thoughts, bizarre, odd behaviors, speech, and thoughts)	<input type="checkbox"/>	Anxiety (Social anxiety, generalized anxiety, panic symptoms)	<input type="checkbox"/>	Anger Control (The youth's ability to manage their anger)
<input type="checkbox"/>	Impulsivity/Attention (Challenges with impulse control)	<input type="checkbox"/>	Oppositional Behavior (disrespectful, argumentative behaviors, difficulty with accepting rules from authority figures)	<input type="checkbox"/>	Conduct (Antisocial behaviors including stealing, vandalism, cruelty to animals, assaultive behaviors)
<input type="checkbox"/>	Depression (Irritable or depressed mood, isolative, withdrawn behaviors, thoughts of hopelessness, sleep and appetite changes, loss of motivation)	<input type="checkbox"/>	Exposure to Implicit Trauma (Implicit trauma refers to experiences and historical events which may not result in specific memories or overt reactive behaviors, but may contribute to current behavioral/ emotional symptoms) ex. Adoption, loss of a family member	<input type="checkbox"/>	Exposure to Explicit Trauma (Explicit trauma refers to traumatic experiences which directly correlate with post-traumatic emotional and behavioral symptoms) ex. Sexual molestation
<input type="checkbox"/>	Problematic Technology Use (The impact of the technology use on the youth's daily functioning including their ability to maintain relationships, complete school work etc.)	<input type="checkbox"/>	Gambling (Youth's involvement with all forms of gambling, legal and illegal)	<input type="checkbox"/>	Other:

Detailed description of all checked behaviors/symptoms; please include any current presenting symptoms and any history of these symptoms:

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Youth Risk Behaviors (please check any issues that are relevant to the treatment needs of the youth and/or exhibited in the last 30 days):

<input type="checkbox"/>	Suicide Risk (This includes suicidal thoughts, plans, and behaviors)	<input type="checkbox"/>	Danger to Others (This includes actual and threatened violence)
<input type="checkbox"/>	Flight Risk (This includes any planned or unplanned wandering, impulsive running; consider age of the youth, frequency, duration of escape episodes, timing, and context)	<input type="checkbox"/>	Problematic Sexual Behaviors (This includes any sexually aggressive behavior where an older youth takes advantage of a younger youth) (Specialty Evaluation may be indicated if youth is being referred for OOH treatment)
<input type="checkbox"/>	Other Self Harm (Other high risk behaviors which impacts personal safety and increases the risk of personal injury that is not considered suicidal behavior or intentional self-injurious behavior)	<input type="checkbox"/>	Substance Use (This refers to any use of tobacco, alcohol, or illegal drugs) (Specialty Evaluation may be indicated if youth is being referred for OOH treatment)
<input type="checkbox"/>	Self-Injurious Behaviors (Any intentional self-harming behaviors that does not have suicidal intent)	<input type="checkbox"/>	Judgment (This refers to the youth's decision-making ability)
<input type="checkbox"/>	Legal/ Juvenile Justice (This includes any behavior which a youth exhibits that results in involvement with the legal system)	<input type="checkbox"/>	Fire Setting (This refers to when youth intentionally start fires) (Specialty Evaluation may be indicated if youth is being referred for OOH treatment)
<input type="checkbox"/>	Other:		

Detailed description of all checked risk behaviors; please include any current presenting risk behaviors and any history of these risk behaviors:

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Youth Strengths (please check any issues that are relevant to the treatment needs of the youth and/or exhibited in the last 30 days):

<input type="checkbox"/>	Family Strengths - Ability to support the youth's overall progress and development	<input type="checkbox"/>	Relationship Stability - Stability of relationships with friends and family
<input type="checkbox"/>	Talents / Interests which the youth exhibits	<input type="checkbox"/>	Community Involvement - The quality of the youth's connection to their community
<input type="checkbox"/>	Youth's involvement with care and treatment planning	<input type="checkbox"/>	Optimism - Youth's personal sense of optimism
<input type="checkbox"/>	Self-Expression - Youth's ability to express his/her thoughts and feelings	<input type="checkbox"/>	Spirituality - Youth's involvement with spiritual or religious beliefs and practices and activities
<input type="checkbox"/>	Wellness Behaviors - Indicators that the youth exhibits health-promoting behaviors and makes good lifestyle choices	<input type="checkbox"/>	Resiliency - The youth's innate ability to enjoy positive life experiences and manage negative life experiences
<input type="checkbox"/>	Other:		

Detailed description of all checked strengths:

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Life Domain Functioning (please check any issues that are relevant to the treatment needs of the youth and/or exhibited in the last 30 days):

<input type="checkbox"/>	Living Environment (This refers to the youth's functioning in the current living arrangement)	<input type="checkbox"/>	Cultural Stress (This refers to experiences and feelings of discomfort related to real or perceived conflict between an individual's own cultural identity and the predominant culture in which he/she lives in. This includes language barriers, age, gender, ethnicity, physical disability etc.)
<input type="checkbox"/>	Interpersonal Functioning (This refers to the youth's interpersonal skills involving his relationships with peers and non-related adults)	<input type="checkbox"/>	Attachment (This refers to the youth's development of physical and emotional bonding and boundaries with others, specifically within the context of the youth's significant parental or caregiver relationships)
<input type="checkbox"/>	Medical Needs (This includes both acute and chronic medical conditions)	<input type="checkbox"/>	Sleep (This refers to the youth's ability to fall asleep, stay asleep, and wake up on time in the morning)
<input type="checkbox"/>	Eating (This refers to any potential concerns in regards to the youth's food intake, such as overeating, undereating, unusual eating disturbances, and eating disturbances related to distorted body image cognitions)	<input type="checkbox"/>	Sexual Health (This refers to the youth's physical, emotional, mental, and social wellbeing in relation to sexuality)
<input type="checkbox"/>	School Behavior (This refers to any disruptive behavior which the youth exhibits in a school or day care setting)	<input type="checkbox"/>	School Attendance (This refers to how consistently the youth attends school)
<input type="checkbox"/>	Academic Achievement (This refers to the youth's grades and test scores)	<input type="checkbox"/>	Bullied by Others (This refers to the degree to which a youth has been bullied or is being bullied by others)
<input type="checkbox"/>	Learning Disability (This refers to any innate difficulty in a specific academic subject which could require additional educational supports)	<input type="checkbox"/>	Developmental Delay/ Intellectual Disability (Autism, Cerebral Palsy, Down Syndrome, and other Genetic Disorders are rated here)
<input type="checkbox"/>	Educational Agency Involvement (This refers to the School's ability to address youth's educational and behavioral health needs; and the quality of the school's relationship with the youth and family)	<input type="checkbox"/>	Other:

Detailed description of all checked life domain functioning needs; please include any current presenting life domain functioning needs and any history of these life domain functioning needs:

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Caregiver Information/Needs:

Caregiver Name:	Caregiver Relationship to Youth:
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Caregiver strengths and needs (check all that apply):

<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Substance Use	<input type="checkbox"/> Safety of Immediate Living Environment
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Knowledge of Youth’s Strengths/ Needs
<input type="checkbox"/> Caregiver Optimism	<input type="checkbox"/> Family Stress	<input type="checkbox"/> Caregiver Resourcefulness
<input type="checkbox"/> Residential Stability	<input type="checkbox"/> Caregiver Physical/ Medical Needs	<input type="checkbox"/> Caregiver Mental Health Needs
<input type="checkbox"/> Caregiver Substance Use Needs	<input type="checkbox"/> Caregiver Needs related to Intellectual/ Developmental Disability	<input type="checkbox"/> Caregiver’s ability to provide a Safe Environment
<input type="checkbox"/> Caregiver Needs involving Transitioning from Military Services		

Detailed description of all checked caregiver strengths and needs:

For youth being referred for Out-of-Home Treatment:

If the youth has not been successful with community-based services and supports - please describe, in detail, the reasons why community based services and supports were not successful.

What are the resources, supports, and alternative interventions that could be considered in order to potentially maintain the youth in the community? Please comment on caregivers strengths, abilities, and limitations in regards to successful maintenance of the youth in the community:

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History of Treatment & Youth System Involvement:

(Provide detailed information for all applicable sections including start/end dates and name of provider/agency/facility – limit to the past 3 years):

Behavioral Health (include: Outpatient, Intensive In-Home, Partial Hospitalization/ Partial Care Programs, Out of Home, Inpatient Hospitalizations)

Substance Use (include type of substance, pattern of use, age of onset, types of treatment- Outpatient, Intensive Outpatient, Partial Hospitalization Programs, Short Term Residential, Long Term Residential, Detoxification, Inpatient hospitalizations):

Physical Health/ Medical (include active issues):

Specialty Needs (include fire setting, problematic sexual behavior, cruelty to animals, and assaultive behaviors, which has occurred at any point in their lifetime – also include details in regards to the severity and frequency of these behaviors and timeline with most recent occurrence):

Youth Welfare/DCP&P (include history of abuse or neglect and descriptions including duration, perpetrator; services including in home services, resource/foster home, therapeutic treatment home):

Juvenile Justice (include case pending, FCIU, probation, detention, day program, DAP, incarceration, parole):

School (include type of school placement, i.e. regular education, special education, in district/out of district, home instruction):

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Information Sources (e.g. Parents, Foster Parents, Group Home Worker, Probation Officer, teacher etc.):

Name	Relationship to Youth	Phone Number

Printed Name of Assessor:	
Signature of Assessor:	
Credentials:	Date:

Once the form is complete, please fax to **1-877-736-9166**.

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*All referents are legally required to report suspected youth abuse or neglect to DCP&P at: **1-800-NJ ABUSE**