Psycho-Social Assessment

(to be completed by a mental health professional)

Who can complete this page?	A) The applicant's mental health professional such as their social worker, psychologist, psychiatrist B) The medical professional that prescribed the medication or diagnosed the behavioral, mental or emotional condition

Legal Name of Camper/Patient:

How was the camper referred to you? ☐Family ☐Court Mandate ☐ School ☐ Other: ______________________

When did the treatment begin? ______________________ Date of most recent visit: ________________________

Number of visits in the past 6 months _________________ How often is the camper currently seen? ____________

Behavioral manifestations that may appear at our camp program: ____

____

____

____

____

Behavioral, Emotional, or Mental Health Diagnosis/Reason for Treatment: ___________________________________

Date of Diagnosis (if formal DSM diagnosis):_______________ Essential Meds for Diagnosis:____________________

Criteria met that led to that diagnosis: ____

Please recommend ways to manage camper's behavioral situations: _______________________________________

____

To your knowledge, is there or has there ever been a concern about any of the following? (Check all that apply)

Passive or active suicidal ideation or plans Self-harm Impulse control Aggression

If any of these items are checked, please explain: ____

____

Can this child function at camp with only **basic** care from the on-site mental health provider? YES NO

Any other comments/limitations/restrictions: ____

VERIFICATION BY MENTAL HEALTH PROFESSIONAL:

I understand that the above listed individual is seeking to participate in The Laurel Foundation's overnight camp program for transgender youth. The camp program provides a Medical Team consisting of nurses and a mental health professional on-site and/or an on call 24-hours a day to provide basic care during camp.

Based on this understanding and my work with this individual, I believe The Laurel Foundation should
ACCEPT or **DECLINE** this application.

Provider Name:	Title:
Signature:	Date:
Agency/Hospital Affiliation:	Phone: