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 youth affected by HIV/AIDS and/or transgender/gender-diverse youth. The camp program provides a Medical Team consisting of nurses and a mental health professional onl site and/or an on call 24l 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: