The MDE is a *point-in-time* screening performed soon after a child’s entry into DCF’s care.

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| **GUIDELINES FOR COMPLETING THIS TEMPLATE** |
| 1. **Mental Health Narrative** - Highlighting the most salient points of the MDE.
2. **Need**: Write in the child's need identified during the evaluation.
3. **Need Based Recommendations** - List the recommendation(s) that will address the identified need. Include one or more of the following:
	* Consult
	* Monitor
	* Refer for:
		+ further evaluation
		+ treatment
		+ intervention
		+ service activity
	* If recommending “monitoring”, please indicate specific symptoms, what to do if symptoms do not improve and/or worsen.
	* If recommending “further evaluation”, please indicate specific issue, type of provider and specific referral questions.
	* If referring for “treatment/intervention”, please indicate specific type and goals.
	* Recommendations must include one of the following timeframes:
		+ Emergent (with-in 2 hours)
		+ Urgent (within 2 days)
		+ Routine (Consistent with established standards) specify time frame
		+ On-going
		+ Other - provide detail
	* If there are emergent/urgent needs identified, the clinic should contact DCF within the established timeframes (2 hours - 2 days) and document how, when and to whom at DCF this information was communicated.
	* If the identified follow-up timeframe is less than 4 weeks, or prior to the DCF area office receipt of the MDE Summary and Recommendations, the clinic should also contact DCF.

No new information should be presented in this summary. The summary should not include details about any person other than the child. |
| **CHILD INFORMATION** |
| Child/Youth LAST Name:      | Child/Youth FIRST Name:      | DOB:      | Gender:      |
| DCF Office:      | DCF Office Phone:      | Case ID #:      | Person ID #:      |
| MDE Clinic:      | MDE Phone:      | Date of MDE:      |
| Release of information DCF-460-MDE-A, “MDE Child/Youth Permission for Release of Information” (Required for youth age 13 – 17 as to substance use & reproductive health): [ ]  Exam/consult was not provided due to:      [ ]  Information is included. Child signed the DCF-460-MDE-A [ ]  Information is not included. Child has NOT signed the DCF-460-MDE-A |
| **DSM-5 Diagnoses:**       |
| **MENTAL HEALTH DEVELOPMENTAL SUMMARY** |
| Narrative: Highlighting the most salient points from history, presentation during MDE, test results, mental status exam, trauma screen and other relevant information presented in the MDE report as well as concise yet comprehensive and integrated conceptualization of the child's overall mental health/developmental levels of functioning.      |
| **MENTAL HEALTH, DEVELOPMENTAL, TRAUMA AND EDUCATIONAL NEEDS**  |
| Trauma Needs [ ]  Yes [ ]  No [ ]  N/A If yes, please add: the identified need(s), recommendation(s) and time frame(s)” below. |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:       |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:       |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:       |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:       |
| **MEDICAL NEEDS** |
| Summarize the findings from the Medical Evaluation and Physical Exam. Briefly describe any significant problems:      List Medical Problems identified in Section IV of the MDE 746 Report:       |
| List current medications (including over the counter). Provide the prescriber’s name and reason for the prescription:       |
| Medical Needs: [ ]  Yes [ ]  No [ ]  N/A If yes, please add: the identified need(s), recommendation(s) and time frame(s)” below |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:       |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:       |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:       |
| **DENTAL NEEDS** |
| Summarize the findings from the Dental Exam. Briefly describe any significant problems:       |
| Dental Needs: [ ]  Yes [ ]  No [ ]  N/A If yes, please add: the identified need(s), recommendation(s) and time frame(s)” below |
| 1. Need:
2. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

Time Frame:      1. Recommendation:

T Time Frame:       |
| **MULTIDISCIPLINARY EVALUATION PROVIDER NAMES** |
| Clinic Coordinator:      | Date:      |
| Mental Health Evaluator:      | Date:      |
| Supervising Licensed Clinician:      | Date:      |
| Medical Provider / Physician / APRN:      | Date:      |
| Dental Provider:      | Date:      |
| **FOR DCF STAFF ONLY** |
| Summary of Findings sent to: | [ ]  Primary Medical Provider on (*enter date sent*): | [ ]  Foster Parent on (*enter date sent*):  |
| Social Worker:      | Social Worker Supervisor:  | DCF Office:      |