Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

PARIS
PRIMARY ACCESS
Regional Information System

# MENTAL HEALTH CHILD AND YOUTH BRIEF ASSESSMENT

**Name:** **Team:**
**DOB:** **Age:** **PARIS ID:**
**Gender:** **PHN:**

## Header Details

Date Started: End Date:
Carried Out By: Assessment ID:
Recorded By: Assoc. Referral ID:

## Identifying Data and Reasons For Referral

## History of Presenting Problem

## Brief Social, Family and Educational Functioning

## Mental Status Examination (MSE)

## Formulation

## Diagnosis

| Date | Diagnosis Type | Diagnosis | State | Aware? | Comments |
|---|---|---|---|---|---|

## Treatment Plan

## Needs

| Need | Post to C/P | Processed | Comments |
|---|---|---|---|

## Comments

## Other People Involved with Assessment

| Who | Association | Comments |
|---|---|---|

## Copies To Be Sent To

## Other Authorizers

Authorizer: Date:
Authorizer: Date:

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| | | |
|---|---|---|
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## Authorization Details

Carried Out By: Date:

Authorized by: Date:

Notes:

## Casenote (may have been added after assessment authorized)

**------------------------------------------------------------ End of Report ------------------------------------------------------------**