Comprehensive Assessment Update – Child/Adolescent Version

This form has been designed to reduce provider agency risks and to save time. It provides a standard and efficient format for updating diagnostic information, re-admitting persons served (according to agency policy and procedures), and/or updating the clinical formulation and treatment recommendations. This new/additional information, which is often not easily identifiable in progress notes, creates audit risks for provider agencies. It must be clear to auditors how assessed needs, treatment recommendations and treatment are linked, especially when the information in the diagnostic assessment is outdated.

This form does not replace initial evaluations or assessments.

It is recommended that this form be kept in date order in the comprehensive assessment portion of the child's record. In all cases, provider agencies should determine whether the new/additional information contained in this form requires an updated Individual Action Plan (IAP) to be completed.

This form can be used whenever the provider believes that updated diagnostic information should be included in the medical record. Some organizations may want to routinely require updates on an annual basis, or when the person returns to care within a fairly short time period, or when the person changes level of care. The completion of a Comprehensive Assessment Update form does not necessarily assume billing of a comprehensive assessment service. For example, data obtained during an individual therapy session that constitutes important new assessment information can be recorded on the Comprehensive Assessment Update while the service itself would have been documented and billed as Individual Therapy.

Data Field	Identifying Information
Person's Name	Record person's first, last name and middle initial. Order of name is at agency discretion.
Record Number	Record agency's established identification number for the child served.
Organization Name	Record the organization for whom you are delivering the service.
Data Field	**Section I: Reason for Update**
Annual Update, Re-Admission and Interim Update of New Information	Check the appropriate box to indicate whether the Update is: • an Annual Update of the Comprehensive Assessment (if required by agency policy and procedures and/or accreditation), • a Re-Admission Update for a child who left services and has returned to services within one year of the date of the last Comprehensive Assessment in the health record, or • an Interim Update of New Information while the child is in service that provides a therapeutic basis for additional services. Refer to the introduction above for clarification of each type of indicator.
Data Field	**Date of Most Recent Assessment**
Date of Most Recent Comprehensive Assessment	Enter the date of the last Comprehensive Assessment in the health record for the child.
Data Field	**Child/Adolescent Comprehensive Assessment Section(s) for Update**
Comprehensive Assessment Sections	Check all applicable boxes next to the section(s) of the Comprehensive Assessment being updated. All additional information being updated must be labeled in the narrative section of this form with the Comprehensive Assessment section heading. * Updates may require an IAP Revision or a new IAP. Annual Updates and Re-Admissions may require a new IAP if there are changes to treatment including goals,

	objectives and services offered.
Data Field	**Update Narrative**
Update Narrative	Provide a narrative explanation for each box selected in the section above. List each as a separate heading and write the narrative below.
Signature/Credentials	If the above sections are completed by an unlicensed staff (e.g., CSP Outreach Worker), the staff completing these sections signs here and adds his or her credentials. *The remainder of this document must be completed by a licensed clinician who will sign in the box below and again at the bottom of the completed document.
Date	Enter date the unlicensed staff completed and signed Section I.
Data Field	**Section II: Diagnosis Change**
Diagnosis Change	If there is any change or addition to the diagnosis, this section is used to record a full diagnostic picture including any changes to diagnoses. **Check the correct box designating no change in diagnosis or all current diagnoses.** Record all current, active diagnoses (including changed diagnoses) that will provide support for the medically necessary services provided to the person served. Diagnoses can be recorded in either ICD-9 CM codes and narrative or DSM codes and narrative. Check the appropriate box at the top of this section to indicate if you are using ICD-9 or DSM codes. ***ICD-9 CM Codes:** List codes in appropriate order using ICD coding conventions. List next to each code the narrative description of the code from the ICD-9 CM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. ***DSM Diagnostic Codes:** List codes next to appropriate Axis designation using DSM coding conventions. Up to two Axis I and Axis II diagnoses can be recorded. All five axes can be recorded in this section. Next to the codes list their narrative description from the DSM code book being used by the Agency. All five diagnoses can be recorded on the document. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. Record Current GAF and Highest GAF in past year (if known). **Note:** Providers should ensure familiarity with regulations governing who can diagnosis mental illness and adhere to state licensing laws as applicable.
Data Field	**Child/Family/Guardian Expression of Services Preferences**
Service Preferences	It is important for the clinician and child, as well as his/her family or guardian, to have a meaningful dialogue to engage and allow the child and his/her family or guardian to express their treatment preferences and priorities. Identify the indicated needs/preferences of child/family/guardian for the full range of behavioral health clinical and community-based rehabilitative services, and environmental support services available to them.

Data Field	Treatment Recommendations/Assessed Needs
Treatment Recommendations / Assessed Needs	If, upon review of the most recent Child Comprehensive Assessment and the information from this update there are no additional recommendations or assessed needs, check the box **No Additional Recommendations Clinically Indicated**. If there are additional Treatment Recommendations/Assessed Needs the clinician, child and family/guardian should collaborate to identify and prioritize needs. These identified needs should be considered as the basis for subsequent treatment goals and/or objectives and all should be geared to improving the functioning of the child or reducing his or her signs and symptoms. **Examples**: • **Decrease symptoms of depression** • **Reduce suicidal ideation** • **Education about illness and treatment options** • **Enhanced management of active symptoms** • **Medication stabilization** • **Reduction of anger episodes** • **Development of symptom management skills**
Person or Family/Guardian Declined/Deferred/Referred Out Rationale(s) (Explain why Person or Family/Guardian Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out below)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by person served or family/guardian to decline a recommendation at this time.
Data Field	**Further Evaluations Needed**
Further Evaluations Needed	Check the box(es) that identify additional assessment needs of the child (if any).
Data Field	**Was Outcomes Tool Administered?**
Was outcomes tool administered?	This is an optional field. Providers may choose to or have contract requirements relative to outcomes. Information pertaining to outcomes should be entered in this section. In some cases, the provider may wish to note the name of the instrument and most recent administration. The instrument and results may be located elsewhere in the medical record, however, this information should be used to assist in the development of treatment plan updates.
Data Field	**Level of Care**
Level of Care/ Indicated Services Recommendation	Recommend and record the least restrictive level of care that is safe for the child based upon the presentation of the child/family. The determination needs to be strongly supported by the symptoms, behaviors and skills deficits and abilities/needs documented in the earlier sections of the assessment or this update. Level of Care should be directly linked to medical necessity evidenced by the documentation throughout the assessment. Also, indicate the services within the Level of Care chosen to meet the identified clinical needs and the service preferences provided to the child /family. **Example: Outpatient Level of Care with emphasis on Community Support, Individual Therapy and Medical Somatic Services**. If there is no change to the Level of Care/Indicated Services Recommendation, check the "No Change" box.
Data Field	**Response to Recommendations**
Child/ Family/Guardian Response	Record the child's/family's reactions and opinions to your recommendations in this section. You may record a summary or specific verbal responses provided by the child/family/guardian. Also record the child's and family's willingness to participate in

to Recommendations	treatment. If there was no change to the Level of Care/Indicated Services Recommendation above, check “Not Applicable”.
Data Field	**For Annual or Interim Updates**
Change In IAP Required	If the assessed therapeutic needs can be supported by the Goals, Objectives, Interventions, services, frequency, duration and responsible provider(s) in the current IAP, then an IAP Revision/Review is not required. If the assessed treatment needs cannot be supported by the current IAP, then a change in the IAP is required. Please indicate the change by completing an IAP Revision/Review form.
Data Field	**Signatures**
Provider - Print Name, Signature and Credential	Legibly print name and record legible signature of the clinician involved in the gathering and completion of the assessment. Record the educational level and the highest license level of the clinician involved in the gathering and completion of the assessment.
Supervisor Print Name, Signature and Credential (If needed)	Legibly print name and record legible signature of the supervisor involved in the gathering and completion of the assessment. Some agencies may have policies requiring supervisor signatures on diagnostic assessments. Record the educational level and the highest license level of the supervisor involved in the gathering and completion of the assessment.
Parent/Guardian Signature (as appropriate)	Record legible signature of the child’s parent or guardian, as appropriate.
MD Signature (required for Opiate Addiction Programs)	Record legible signature of the physician involved in the gathering and completion of the assessment, if applicable.
Person’s Signature (if adult or as appropriate)	If appropriate, record the legible signature of the child served.
Date	Record the date of each signature.
Next Appointment Date/Time	Record the date and time of the child’s next appointment.