PHYSICIAN CERTIFICATION OF SERIOUS EMOTIONAL DISTURBANCE

CLIENT NAME: First: _____ Last:_____ SOC.SEC.NO _____

GENDER: M F O RACE (Circle all that apply): WH AS BL AI/AN NH/OPI ETHNIC HISPANIC: Yes or No

PROVIDER:_____ CLIENT ID NO.: _____ DATE OF BIRTH : _____/_____/_____

Children with a serious emotional disturbance (SED) are persons ***(All boxes must be checked for a child to be certified as SED)*****:**

☐ from birth up to age eighteen (18);

☐ **AND,** who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5)*, **OTHER THAN** "V" codes, substance use disorders or developmental disorders (including mental retardation) which are excluded unless they co-occur with another diagnosable serious emotional disturbance.

DSM Diagnoses (primary listed first):_____

_____

_____;

☐ **AND,** this disorder resulted in functional impairment, which **substantially** interferes with or limits the child's role or functioning in family, school, or community activities. *The functional impairment must result* ***primarily*** *from the diagnosed mental, behavioral or emotional disorder, rather than being primarily the result of a substance abuse/dependence disorder, developmental disorder (including mental retardation) or medical disorder.*

Functional Impairment is defined as:
Difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition. Functional impairments of episodic, recurrent, or continuous duration are included **unless** they are temporary and expected responses to stressful events in the environment.

Briefly list the functional impairments below, and indicate where in the patient record specific, descriptive documentation can be found regarding the functional impairments that result from the diagnosed mental, behavioral or emotional disorder.

_____

_____

I, the undersigned, do hereby certify that I have performed a medical review of the evaluation of this client and that he/she meets the above Division of Behavioral Health Services (DBHS) criteria of serious emotional disturbance.

____ Evaluation based on my direct examination of client within last 45 days (Valid up to one calendar year).
____ Evaluation not based on my direct examination of client within last 45 days (Valid up to 45 days).
____ Evaluation based on my participation in ongoing treatment planning/review process (Valid for period covered by the current physician approved treatment plan).

_____ _____

Physician Signature **Date of Medical Review**

***or the most current version of the DSM in use.**

DBHS-3580 (12/2014)