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Child/Adolescent Services

Interagency Service Planning Team (ISPT) Meeting Summary Form

Purpose of Meeting ☐ Initial ☐ Continued Stay Today's Date: _____

This form completed by (name, credentials): _____

Meeting Location: _____

Demographics

Member's Name: _____ MAID: _____ DOB: _____

Address: _____ Phone #: _____

Member County:

☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth:_____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Involvement with Other Agencies (check all that apply)

	Agency	Agency Staff Name
☐	Children and Youth Services	
☐	Juvenile Probation	
☐	ID Supports Coordinator	
☐	Case Management	
☐	Other: _____	
☐	Other: _____	

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Family Information

Please list siblings, adults, and any others residing in the home. If any of the children residing in the home are receiving mental health services list service type and agency name

First and Last Name	Relationship	Age	Sex	Services	Agency

Who has physical custody of the Member (including relationship to Member): _____

Does this person have medical rights? ☐ Yes ☐ No

If no, who has medical rights for the Member (including relationship to Member): _____

What is that person's address: _____

Medical

Primary Care Physician: _____

Medication	Prescribing Doctor	Agency

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Current Medical Concerns:

Does Member take all medications as prescribed? ☐ Yes ☐ No

If not, why not?: _____

Strengths/Natural Supports

Child/Adolescent Strengths:

Family Strengths:

Community/Natural Support involvement (boys club, girl scouts, piano lessons, etc.). If none, please include a plan for engaging Member in community/natural supports:

School/Educational Information

School Name: _____ Grade: _____

Classroom Placement (check all that apply):

☐ Regular Education
☐ Learning Support
☐ Emotional Support
☐ Partial Hospitalization
☐ Autistic Support
☐ Residential placement
☐ Other: _____

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Does the Member have an IEP? ☐ Yes ☐ No

Does the Member have a 504 Behavior Plan? ☐ Yes ☐ No

Has the Member even been evaluated by a school psychologist? ☐ Yes ☐ No

If yes, when and by whom?: _____

Trauma/Substance Use History

Trauma History:

Substance Use History:

Has the Member ever received treatment for trauma and/or substance use?: ☐ Yes ☐ No

If yes, when and where?: _____

Most recent diagnoses (if applicable): _____

Progress since last ISPT meeting:

☐ N/A – Initial ISPT meeting

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Clinical Presentation

Current symptoms and behaviors (past 1-3 months)

Behaviors	Setting (i.e. Home/School/Community)	Frequency/Intensity/Duration

Barriers to treatment:

Discharge/Aftercare Planning

Proposed discharge plan (including identified discharge resources):

ISPT Team Review of Prescription

ISPT Team is in agreement with evaluator's prescription?: ☐ Yes ☐ No (explain why not below)