Parent Self-Referral Age: 2-years-9-months to 4-years-9-months

Collecting this information from parents/guardians before booking an appointment at CASA allows us to more accurately determine whether CASA Services are appropriate for this child, if the situation should be considered urgent or high priority, and also helps our assessment process work more efficiently. This information will be held in confidence, stored securely until the child is 30 years of age, and accessed only by CASA staff and physicians.

CASA Mental Health protects the privacy of individuals requesting or receiving health services in accordance with the *Health Information Act (HIA)*. Personal and/or health information collected on this form (the Parent Self Referral Intake) will be used for the purpose of providing health services as well as determining or verifying eligibility for those health services as authorized by sections 27(1)(a) and (b) of the HIA. Information is collected pursuant to section 20(b) of the HIA and will occur directly from the individual accessing services except in specific circumstances in accordance with section 22(2)(b). For more information or if you have any questions about this collection, please contact CASA's Privacy Office by email at privacy@casaservices.org or by phone at 780-400-2271.

We are unable to provide autism assessments, and we do not provide autism specific services or therapy. We are unable to provide assessments for insurance claims or medical-legal purposes, including custody.

Date:

Child's Full Legal Name (last name, first name, middle name)		Preferred Name:	
Alberta Health Care Number (required)	Date of Birth (Day-Month-Year)	Age:	Gender: ☐ Male ☐ Female ☐ Other
Specialized Program:		Phone Number:	
Cultural Identity:		Indigenous Status:	
Cultural /Special Considerations:			
Name of current physician/pediatrician		Physician Phone Number:	

Parent(s) / Guardian(s) / Identification

Parent/Guardian:		Parent/Guardian:	
Address:		Address:	
City/Postal Code:		City/Postal Code:	
Home Phone:	Alternate Phone:	Home Phone:	Alternate Phone:
Email Address:		Email Address:	
Please select appropriate descriptors: ☐ Biological ☐ Adoptive ☐ Step ☐ Grandparent ☐ Other		Please select appropriate descriptors: ☐ Biological ☐ Adoptive ☐ Step ☐ Grandparent ☐ Other	
Family Status: ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Single		Family Status: ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Single	

Are parents married, or common law and living in the same home? ☐ Married / ☐ Common Law

If parents are separated, are you both able to attend appointments together? ☐ Y / ☐ N

Who has legal custody? _____

Please attach all court ordered documents (if applicable) □ Court ordered medical decision making documentation, □ Temporary Guardian Order or Permanent Guardian Order documentation, □ Single parents solely listed on birth certificate, □ Previous assessments.

Does this child receive services from Children's Services? ☐ Yes ☐ No

Case Worker's Name: _____ Phone Number: _____

Who referred the child to CASA?

☐ Physician	☐ Children Services	☐ Head Start
☐ GRIT	☐ Family Resource Network	☐ Family Support Worker
☐ Home Visitor	☐ Other _____	
Name of referring party:	Phone number:	Email:
_____	_____	_____

Current Concerns: (please check boxes that apply)

☐ Hyperactivity	☐ Parent-child conflict	☐ Low self-esteem
☐ Obsessive thoughts	☐ Gender and social identity	☐ Prolonged tantrums
☐ Eating/Feeding	☐ Cognitive/learning difficulties	☐ Sleep
☐ Fears and anxiety	☐ Involuntary movements/ sounds	☐ Selective mutism
☐ Aggression towards _____	☐ Regression in development	☐ Social difficulties
☐ Difficulty with separation	☐ Developmental concerns	☐ Lack of boundaries
☐ Daycare/school difficulties	☐ Attention/focus difficulties	☐ Impulsivity
☐ Risky behaviors	☐ Difficulty with transitions	☐ Routinized behavior
☐ Inability to be redirected	☐ Suspected or confirmed exposure to substances during pregnancy	

If necessary, please provide further description below:

_____

_____

_____

Current Medications (please list):

_____

_____

_____

Has your child ever been a victim of abuse? ☐ Yes ☐ No

Has your child ever experienced a traumatic event? ☐ Yes ☐ No

History of trauma (includes suspected):

☐ None ☐ Sexual abuse ☐ Physical abuse ☐ Emotional abuse ☐ Neglect
☐ Exposure to family violence ☐ Other _____

_____

_____

Are you or have you ever been involved with CASA? ☐ Yes ☐ No
If yes, please specify:

Please add any other information regarding your child that you feel would be important for us to know.

Medical and/or mental health assessments and diagnosis:

Current community and/or mental health supports:

What do you hope CASA can do for your family?

Guardians are required to sign this form to ensure they are aware of this request for services from CASA Mental Health.

- In the case where the child's biological parents are not living together, both parents must consent to services and/or provide legal documentation confirming guardianship and medical decision making authority.
- If you have a custody or parenting order in place please include a copy of it with the form.

Signature of person completing this form:	Relationship to child:	Date:
Signature of Legal Guardian:	Relationship to child:	Date:
Signature of Legal Guardian:	Relationship to child:	Date:

If you have any concerns or questions please contact CASA Intake at 780-410-8483