CASA Mental Health

Patient Label

Preschool Day Program Referral: Preschool and Kindergarten

Referral Criteria for Preschool Day Program:

- The referral must be made by a Physician or qualified Health Professional.
- The child must have a Pediatrician or Family Physician.
- The child must meet age criteria for Preschool or Kindergarten.
- The child must meet criteria for Program Unit Funding eligibility.
- The child exhibits complex social-emotional and developmental needs.
- Family and program acceptance/suitability following intake consultation.
- Family is able to transport the child every day.

Patient/Student Information:

Legal First Name:	Legal Middle Name:	Legal Last Name:
Preferred Name:	Date of Birth: (dd-mmm-yyyy)	
Gender: ☐ Male ☐ Female	Health Care Number:	
Address:	City/Town:	Postal Code:
Last School Attended:		

Parent/ Guardian Information:

Name: (print)		Name: (print)	
Relationship to Child:		Relationship to Child:	
Address: (if different from above)		Address: (if different from above)	
City:	Postal Code:	City:	Postal Code:
Phone:		Phone:	
Email:		Email:	

Child and Family Services Involvement: ☐ Yes ☐ No	Child and Family Services Role:	
Child and Family Services Worker:	Phone:	Fax:

The CASA Preschool Day Program (PDP) is a tertiary-level, inter-disciplinary diagnostic and therapeutic educational resource for children aged 4 and 5 who are experiencing severe challenges managing or regulating their emotions and behavior such that they have been unable to participate meaningfully in the home and community options. Associated difficulties with development, executive functioning and learning may be evident.

Referral Information:

Referral Source:		**Family Physician:** (if different)	
Name: (print)		Name: (print)	
Address:		Address:	
City:	Postal Code:	City:	Postal Code:
Phone:	Fax:	Phone:	Fax:
Signature:		Signature:	
PRAC ID:	Date:	PRAC ID:	Date:

Which community based services have been accessed? (Check all that apply. If possible, please provide documents with the referral).

Services	**Date** (dd-mmm-yyyy)	**Location**
☐ Speech-Language Pathology		
☐ Audiology		
☐ Vision		
☐ Occupational Therapy/Physiotherapy		
☐ Mental Health		
☐ Psycho-educational		
☐ Pre-Kindergarten/Head Start Program (IPP)		
☐ Other (i.e., school/program)		
☐ I have reviewed and discussed the details of this referral with the child's family/legal guardian.		Signature:

Referral Details:

List existing diagnoses, medications, allergies, and any general medical concerns. (Attach relevant documents)

Describe your social-emotional and behavioral concerns for this child in detail. (Use additional pages as required)

Parents/Guardians concerns as described by you. (Use additional pages as required)

School functioning and concerns. (Use additional pages as required)

Please return completed form to:

CASA Central Intake
10645 63 Ave
Edmonton AB T6H 1P7
Fax: 780.435.6261

CASA collects information about you in accordance with Section 20 of the Health Information Act (HIA) for the purpose of providing you health services, determining your eligibility for health services, or to carry out any other purpose authorized by the HIA. Your information will be collected directly from you, except in limited circumstances where we are authorized by the HIA to indirectly collect such information. If you have any questions about this collection, please ask your care provider or contact our Privacy department.