



## Referral for Services Age 2-years-9months 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, and accessed only by CASA staff and physicians.

**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.**

### Patient Information:

Legal First Name:	Legal Middle Name:	Legal Last Name:
Preferred Name:		DOB: (dd-mmm-yyyy)
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Two Spirit <input type="checkbox"/> Other		Health Care Number:
Specialized Program:		Phone Number:
Cultural Identity:		Indigenous Status:
Cultural/Special Considerations:		

### Caregiver / Guardian Information:

Name:		Name:	
Relationship:		Relationship:	
Address: (if different from above)		Address: (if different from above)	
Please select appropriate descriptors: <input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Step <input type="checkbox"/> Grandparent <input type="checkbox"/> Other		Please select appropriate descriptors: <input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Step <input type="checkbox"/> Grandparent <input type="checkbox"/> Other	
City:	Postal Code:	City:	Postal Code:
Phone:		Phone:	
Email:		Email:	
Family Status: <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single		Family Status: <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single	
Custody: <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> N/A Please provide legal documents		Custody: <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> N/A Please provide legal documents	
Please attach all court ordered documents (if applicable): <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Court Ordered Medical Decision Making documentation  <input type="checkbox"/> Temporary Guardian Order Documentation         </div> <div> <input type="checkbox"/> Single Parents (solely listed on birth certificate)  <input type="checkbox"/> Permanent Guardian Order Documentation         </div> </div> If parents are separated, are you both able to attend appointments together? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Child and Family Services Involvement: <input type="checkbox"/> Yes <input type="checkbox"/> No	Child and Family Services Worker:
Phone:	Fax:

### Referring Information:

Who referred the Child to CASA?		
<input type="checkbox"/> Physician	<input type="checkbox"/> Children Services	<input type="checkbox"/> Head Start
<input type="checkbox"/> GRIT	<input type="checkbox"/> Family Resource Network	<input type="checkbox"/> Family Support Worker
<input type="checkbox"/> Home Visitor	<input type="checkbox"/> Other: _____	
Name of Referrer:		
Address:	City:	Postal Code:
Email:	Phone:	Fax:

### Current Concerns: (please check boxes that apply)

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

If necessary, please provide further description below:

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Current Medications: (please list)

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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
 ☐ Other: \_\_\_\_\_

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Are you or have you ever been involved with CASA? ☐ Yes ☐ No

If yes, please specify:

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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:
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Signature of Legal Guardian:	Relationship to child:	Date:
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Signature of Legal Guardian:	Relationship to child:	Date:
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**If you have any concerns or questions please contact CASA Intake at 780-410-8483**

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](mailto:privacy@casaservices.org) or by phone at 780-400-2271.