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: ☐ Male ☐ Female ☐ Transgender ☐ Two Spirit ☐ Other		Health Care Number:
Address:		Town/City: / Postal Code:
Specialized Program:		Phone Number:
Cultural Identity:		Indigenous Status:
Cultural/Special Considerations:		
Name of Physician/Pediatrician:		Physician Phone Number:

Caregiver / Guardian Information:

Name:	Name:
Relationship:	Relationship:
Address: (if different from above)	Address: (if different from above)
Please select appropriate descriptors: ☐ Biological ☐ Adoptive ☐ Step ☐ Grandparent ☐ Other	Please select appropriate descriptors: ☐ Biological ☐ Adoptive ☐ Step ☐ Grandparent ☐ Other
City: / Postal Code:	City: / Postal Code:
Phone:	Phone:
Email:	Email:
Family Status: ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Single	Family Status: ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Single
Custody: ☐ Sole ☐ Joint ☐ N/A Please provide legal documents	Custody: ☐ Sole ☐ Joint ☐ N/A Please provide legal documents

Please attach all court ordered documents (if applicable):

☐ Court Ordered Medical Decision Making documentation ☐ Single Parents (solely listed on birth certificate)

☐ Temporary Guardian Order Documentation ☐ Permanent Guardian Order Documentation

If parents are separated, are you both able to attend appointments together? ☐ Yes ☐ No

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

Referring Information:

Who referred the Child to CASA?

☐ Physician ☐ Children Services ☐ Head Start
☐ GRIT ☐ Family Resource Network ☐ Family Support Worker
☐ Home Visitor ☐ Other: _____

Name of Referrer:		
Address:	City:	Postal Code:
Email:	Phone:	Fax:

Current Concerns: (please check boxes that apply)

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

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

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.