Child & Adolescent Behavioral Health
an affiliate of Goodwill Industries

Trauma Informed Day Treatment
INFORMED CONSENT FOR THERAPY REFERRAL FORM

Date of Referral: _____

Student Name: _____ **Date of Birth:** _____ **Sex:** M F **Grade:**_____
Parent(s)/Guardian's Name: _____**Home Address:** _____
Phone#'s: (h) _____ (W) _____ (C) _____
IEP: Yes _____**NO** _____ **If yes, IEP Date:** _____
Best Time and Phone # to Reach Parent(s): _____
Referred by-School: _____ **Staff:** _____**Phone #:** _____

Current Concerns: Mark all that Apply	
Mood/Anxiety Concerns ☐ Self-harm threats or statements/thoughts of death and dying ☐ Cutting/self-mutilation/other self-harm (ie head banging) ☐ Trauma/abuse (physical, sexual, emotional, losses etc.) ☐ Sad/depressed demeanor/crying/lack of energy ☐ Low self-esteem/lack of self-respect ☐ Difficulty coping with stress/excessive worry ☐ Poor hygiene/ daily living skills ☐ Anxious/fidgety or shuts down ☐ Frequent/sudden change in behavior/mood	**Social Concerns** ☐ Difficulty making/lack of friends/loner/rejected ☐ Bullied by peers/picked on ☐ Limited involvement in extra-curricular activities ☐ Excessively quiet/withdrawn/isolated ☐ Poor choice of friends/follower ☐ Family problems (conflicts/domestic violence, supervision/support, divorce)
Behavioral Concerns ☐ Bullying/verbal abuse/threats toward peers/adults ☐ Does not accept responsibility for behavior/blames others ☐ Sexually inappropriate comments/concerns ☐ Lying/misrepresenting events/manipulation ☐ Anger management/problems with temper/fighting ☐ Drug/alcohol use ☐ Reckless behaviors putting self/others at risk	**Classroom Concerns** ☐ Failing grades/worried about grades ☐ Absenteeism/truancy/tardy/skipping classes ☐ Non-compliance with classroom rules ☐ Poor work production/homework/poor participation ☐ Low motivation ☐ Disruptive/ "class clown" ☐ Highly distractible/difficulty concentrating/inattentive ☐ Sleeps during class repeatedly ☐ Too much energy/can't seem to sit still/hyperactive ☐ School work is two or more grades below grade level ☐ Sensory issues/concerns
Other: _____ _____ _____	

***Note**: Due to federal privacy laws, in order for C&A to contact parents and provide feedback to school personnel about the status of referrals made by school personnel, all three boxes need to be checked along with a parent/guardian and a witness signature.

☐ I understand that my child has been referred for counseling services through Child and Adolescent Behavioral Health (C&A).

☐ I give permission for C&A representative to contact me regarding this referral and to provide me with the information I need to initiate the process to get my child into the Trauma Informed Day Treatment program.

☐ I give permission for C&A and (school)_____to ☐ obtain and/or ☐ release information regarding my child as a part of C&A's professional relationship with (school)_____. Information to be obtained and/or released includes all pertinent information regarding the referral and intake process at C&A.

☐ This release will terminate in 90 days from the date of signature. The legal guardian may revoke authorization at anytime by notifying C&A in writing.

My authorization is freely and voluntarily given:

_____/_____ _____/_____
Parent/Guardian Signature Date Witness Signature Date

Fax Informed Consent to Sally Sutterfield at 330-456-9764. Must use this form-old forms will be returned with a request to complete this one-thanks!