CASA
Child, Adolescent and Family Mental Health

Pharmaceutical Nursing Consultation- Request for Service

Thank you for contacting the CASA Pharmaceutical Nursing Program. Your cooperation in completing this form ensures future service provision and funding for this program, as well as the collection of data for reporting.

Today's Date (DD/MM/YYYY):

Contact Information	
Consultee Name:	
Consultee Role (CW / CW Supervisor / District Office Manager/ Other):	
Phone number:	
Email:	
District Office:	

Child Demographics	
CS status:	
Age:	
Placement (ex. foster, group)	
Aboriginal status/ band:	
Weight:	
Gender:	
Height:	

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Adverse Childhood Events (ACES) – check all that apply	
☐ Physical abuse	☐ Household dysfunction
☐ Sexual abuse	☐ Substance misuse within household
☐ Emotional abuse	☐ Parental mental health problems
☐ Lack of basic essentials	☐ Parental separation or divorce
☐ Neglect	☐ Incarcerated household member
☐ Domestic violence	☐ Multiple placement breakdowns

Child Medical/Mental Health Information	
School grade:	
Modified school programming/IPP:	

Mental Health Diagnoses		
☐ ADHD	☐ Anxiety	☐ Autism Spectrum Disorder
☐ ADD	☐ OCD	☐ Schizophrenia
☐ FASD	☐ PTSD	☐ Expressive language challenges
☐ RAD	☐ Depression	☐ Receptive language challenges
☐ ODD	☐ Bipolar Disorder	☐ Developmental delays
☐ Conduct Disorder		☐ Other:

Additional Medical Information

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GOA Medical 9.1.2 Policy	
The consent of the Child and Family Services Regional Director, DFNA Director or their designate **is required** for a child in the care of the director under a TGO, PGO, or PGA to receive: medication that alters the mind, thought or behavior; therapy that is significant, sensitive, high risk, radical or innovative. Does this consult involve new psychotropic medication prescription or medical treatment that falls under GOA Medical 9.1.2 Policy? ☐ Yes ☐ No **If Yes:**	
Medications For Consult (Please list all prescribed medications)	
Name:	
Dose:	
Frequency:	
Government Consent: ☐ Yes ☐ No	
Name:	
Dose:	
Frequency:	
Government Consent: ☐ Yes ☐ No	
Name:	
Dose:	
Frequency:	
Government Consent: ☐ Yes ☐ No	
Name:	
Dose:	
Frequency:	
Government Consent: ☐ Yes ☐ No	

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Name:	
Dose:	
Frequency:	
Government Consent: ☐ Yes ☐ No	
Name:	
Dose:	
Frequency:	
Government Consent: ☐ Yes ☐ No	
Name:	
Dose:	
Frequency:	
Government Consent: ☐ Yes ☐ No	
Questions related to **medical interventions that fall under GOA CS Medical Policy 9.1.2** can be written below:	
If No: **General non-medical requests for information** can be written below:	

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Service Evaluation
It is important for us to track the efficacy of our consultation service to ensure that we are providing the most appropriate and accessible service possible. Do you consent to a CASA Evaluator contacting you by email to ask about your experience with this service? ☐ Yes ☐ No Your input helps us grow and develop. It also helps us with funding needs. Your feedback matters and we listen!

Please email this request for service form to
pharmnurse@casaservices.org