Trauma and TAG Referral Package – Program Overview

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 or adolescent and also helps our assessment process work more efficiently. Providing this information is voluntary and it will be held in confidence, stored securely until the adolescent is 18 years of age and accessed only by CASA staff and physicians.

The information collected on this intake form is used to access the services of CASA Child, Adolescent and Family Mental Health and is collected pursuant to section 22 (2)(b) of the Health Information Act (HIA) in accordance with sections 20 (b) and 21 (1)(a) of the HIA. If you have any questions about the collection of this information, please contact CASA's Health Records at 780 400 4563. The Health Information Act and/or Freedom of Information Act protects the privacy of this information.

Trauma Clinic

CASA's Trauma Clinic uses trauma-informed approaches and evidence-based practices for children experiencing or affected by attachment disorders and/or complex developmental trauma.

This specialized program offers individual therapy sessions for children/youth and their caregivers. It is designed to support children to resolve trauma symptoms through healthy attachment to their caregivers. Trauma and Attachment Groups (TAG) may be available as part of treatment in the Trauma Clinic, should criteria be met.

The Program

- Treatment focuses on resolving the symptoms of trauma by supporting healthy parent-child relationships
- Families may take part in individual, play, and group therapy
- Treatment time varies with individual needs

Who It's For

- Children and youth aged 5-18 years
- Children and youth with primary challenges associated with complex developmental trauma and/or attachment concerns; and
- Are living in a secure, safe home for a minimum of 6 months with committed parents/guardians; and
- Have parents/guardians that are able to commit to attending dyadic therapeutic sessions with their child

Trauma and Attachment Group (TAG)

CASA's Trauma and Attachment Group (TAG) uses trauma-informed approaches and evidence-based practices for children experiencing or affected by attachment disorders and/or complex developmental trauma.

This specialized program is designed to promote healthy attachment between children and caregivers living in biological, adoptive, foster, or kinship families.

The Program

- 32-week program, offered twice per year in September and January for the 5-12 year cohort, and once per year in September for the 12-17 year cohort
- Treatment focuses on resolving the symptoms of trauma by supporting healthy parent-child relationships

Who It's For
Children and youth aged 5-17 years who have been:

- Diagnosed with an attachment disorder; and
- Are living in a secure, safe home for a minimum of one year with committed non-biological parents or guardians or biological parents not involved in the trauma story
- Families should be relatively stable and able to participate in treatment for up to two years

Trauma and TAG Referral Package

Referral Source: ☐ Mental Health Therapist (private) ☐ Mental Health Therapist (AHS) ☐ Psychiatrist ☐ Primary Health Physician

Looking to refer to: ☐ Trauma Clinic ☐ Trauma and Attachment Group Program

NOTE: a COMPLETED and detailed referral package MUST be completed for referral to be considered

Referring party name:	Phone:
Family physician name:	Phone:
Pediatrician name (if applicable):	Phone:
Psychiatrist name (if applicable):	Phone:

<table>
<tr><td colspan="4">Child’s Full Legal Name (last name, first name, middle name)</td></tr>
<tr><td>Alberta Health Card Number</td><td>DOB</td><td>Age</td><td>Gender
☐ M ☐ Non-binary
☐ F ☐ Intersex
Other (please specify):</td></tr>
<tr><td colspan="4">Child’s address</td></tr>
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Parent/Guardian 1	Parent/Guardian 2
Full name:	Full name:
Please check appropriate descriptors ☐Biological ☐Adoptive ☐Step-parent ☐Grandparent ☐Foster-parent ☐Other	Please check appropriate descriptors ☐Biological ☐Adoptive ☐Step-parent ☐Grandparent ☐Foster-parent ☐Other
Address	
Phone	

Who has legal custody? (note: If biological parents are not together, legal document must be provided).

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Attached legal document: ☐Yes ☐No

Has the child lived in a secure, safe home for a minimum of 6 months with committed parents or guardians?

☐Yes ☐No

Has the child lived in a secure, safe home for a minimum of 1 year with committed non-biological parents or guardians or biological parents not involved in the trauma story?

☐Yes ☐No

To the best of your knowledge, is the child actively exposed to trauma presently?

☐Yes ☐No

If yes, please explain:

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List everyone living in the home and their relation to the child (please attach a genogram if available):

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Is this child/youth receiving services from Child and Family Services? ☐ Yes ☐ No ☐ Past Involvement

If the answer is “yes” or “past involvement”, what services were received?

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Does this child have Family Support for Children with Disabilities (FSCD) support? ☐ Yes ☐ No

If yes, please include the FSCD worker’s name and contact number:

Worker Name: ________________________ Contact number:_____________________

Does this child have Supports for Permanency (SFP) support? ☐ Yes ☐ No

If yes, please include the SFP worker's name and contact number:

Worker Name: ________________________ Contact number:_____________________

Child's Guardianship Status (if applicable)

☐ Permanent Guardianship Order (PGO)

☐ Temporary Guardianship Order (TGO) Expiry date: _____________________

☐ Interim Custody Expiry date: _____________________

☐ Custody Agreement Expiry date: _____________________

School: ____

Grade: _____

Please indicate any school-related difficulties the child may be experiencing:

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Main contact at school (eg. Teacher/ VP/ Principal/ Success Coach):

Name: ________________ Contact number: ___________________

Has a psychoeducational assessment been competed? ☐ Yes ☐ No ☐ Waitlisted

****If YES, please attach assessment to this document.***

If waitlisted for an assessment, please indicate the organization that the child is waitlisted at:

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Please indicate the risk issues present in the child:

Risk to self

Self- Harm:☐ Yes ☐ No ☐ Past; Date of last self harm episode:
Suicidal Ideation (SI): ☐ Yes ☐ No ☐ Past; Date of last SI episode:
History of suicide attempts: ☐Yes ☐ No ☐ Past; Date(s) of last attempt:
Restrictive eating:☐Yes ☐ No ☐Past; Date of last restrictive eating episode:
Substance Use:☐Yes ☐No ☐Past; Substance of choice:

****Please attach the most recent safety plan completed or reviewed with the child and family (if applicable).***

Risk to others

Aggression towards adults: ☐ Yes ☐ No ☐ Past

Aggression towards peers: ☐ Yes ☐ No ☐ Past

Aggression towards animals: ☐ Yes ☐ No ☐ Past

Destruction of property: ☐ Yes ☐ No ☐ Past

What are the current trauma-related symptoms and diagnoses (if available) for this child or youth?

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Is this child currently prescribed any medication? ☐ Yes ☐ No

If yes, please specify medication & dosage:

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Please list any presenting issues within the family system (e.g., existing dynamics that may destabilize the family system, known or queried mental health and physical health challenges for caregivers):

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Please describe, in chronological detail, the client's trauma history:

In-Utero history *(e.g., birth mother's physical and mental health, exposure to domestic violence, transient living conditions etc, use of any substances during pregnancy)*:

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Birth and delivery *(e.g., indicate any difficulties around birth and delivery, low Apgar scores, emergency procedures, pre-mature births, low birthweight etc.)*

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Infancy (ages 0-1)

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Toddlerhood (ages 1-3)

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Early childhood (ages 4-8)

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Middle childhood (ages 8-10)

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Adolescences (ages 11-18)

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Were there any delays with the child's developmental milestones? ☐ Yes ☐ No

If "yes" please provide further details below:

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Please list the mental health supports the child/youth has received or is currently receiving (e.g., community mental health, in-home behavioural consultant).

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For referring mental health therapists: What therapeutic approaches have been trialled? What has or has not worked?

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Supporting document checklist

To complete the referral package, please ensure that the required supporting documents are attached to this referral package.

☐ Legal custody documentation (**required** for kinship, foster, adoptive families or if biological parents are no longer together)

☐ Current safety plan (**required** if there is a current risk of suicidal ideation or self-harm at the time of referral)

☐ Psychoeducational report (highly recommended if an assessment had been completed prior)

☐ Genogram (optional)

Referral Source: ______________________________________ **Date** _________________

Signature: ____