Children's Hospital
London Health Sciences Centre

Child and Adolescent Mental Health Care Program Outpatients
800 Commissioners Rd. E., Zone B, 8th Floor, P.O. Box 5010, London, ON N6A 5W9
Telephone: 519-667-6640 | Email: CAMHintake@lhsc.on.ca | Fax: 519-667-6814

Child & Adolescent Mental Health Care Program Referral Package
Information for Families

Thank you for considering a referral to the Child and Adolescent Mental Health Care Program (CAMHCP). In order to help us determine whether our service best meets the needs of your child/youth, we ask that you complete the parent (for children 11 years and younger) or both parent and youth (for ages 12 years and older) CAMHCP intake questionnaire(s). We request that family physicians complete the physician's referral page. If you do not have a family physician, you can obtain one through the Health Care Connect website.

Please return the completed questionnaires to either the physician making this referral on your behalf, or submit to the CAMHCP Centralized Intake Department by mail, fax or secure email. Once your completed questionnaire is received we will begin processing the referral. In order for us to provide the best services for you and your family, please include any previous psychiatric assessments, psychoeducational assessments, and/or IEP's.

Mail to: Child & Adolescent Mental Health Care Program, Intake Office, 800 Commissioners Rd. E., Zone B, 8th Floor, Room 157, P.O. Box 5010, London, ON N6A 5W9
Fax: 519-667-6814
Secure Email: Please contact the intake office for instructions.
Phone: 519-667-6640.
Email: CAMHintake@lhsc.on.ca

Once the completed referral package is received, the package will be reviewed by intake staff to determine if the services offered within our program would best meet the needs of your child.

Accepted patients will be offered a diagnostic assessment and recommendations will be provided. These recommendations may include treatments offered through our program, or services available in the community. If it is determined that your child would be best served by another agency or service, you will receive a letter informing you of this with resource recommendations.

If you need assistance completing the referral information package due to language, literacy, or other such barriers, please contact the Centralized Intake Department. Children's Hospital provides various supports to families receiving care including the Family Advisory Council and the Child Life Program resource to assists patients and famililies with identified needs.

If your child is in need of crisis support, please contact Tandem at (519) 433-0334 or visit the Emergency Department at Children's Hospital.

Please see the next page for further information about what you can expect if you are accepted to our program.

Sincerely;
Centralized Intake Department
Ambulatory Child & Adolescent Mental Health Care Program

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Below is some basic information about our program that is important to know and may help you decide if our services are a good fit for your family's needs.

- We offer assessment and/or treatment for children 17 & under who are experiencing acute mental health difficulties primarily with mood, suicidality, self-harm, anxiety, or psychotic symptoms.
- Our program provides mostly group-based interventions and individual treatment is offered only when clinically indicated.
- For those children and youth accepted for hospital-level service (including outpatient), a combination of medication and therapy is often recommended to help them feel better.
- Sessions may be virtual or in person; depending on hospital guidelines, there may not be flexibility around this.
- Treatment is skills-based and/or focused on goals created together with the child/youth and caregivers. For success, goals need to be regularly worked on between appointments.
- Parents/caregivers play an active role in assessment and treatment and are encouraged to attend sessions as recommended.
- Treatment length is typically 12-20 sessions, with regular attendance expected. Treatment is usually weekly, but could be more or less frequent depending on the treatment. We recognize this can be a large time commitment and is needed to get the most benefit.
- Outpatient assessment and treatment appointments are typically offered between 8 a.m. and 4 p.m. or 9 a.m. and 5 p.m. Monday to Friday. We understand this is during regular working and school hours. When requested, we are able to provide documentation to confirm appointment attendance.
- It is expected that children/youth and/or caregivers will attend all scheduled appointments. If canceling an appointment, staff will require at least two-days notice. Unfortunately, our available appointment slots are limited - we want to be fair to all needing services in rescheduling.
- Repeated nonattendance for sessions (e.g., three missed sessions or frequent cancelled sessions) may mean that further services may not be able to be offered. Our team will do our best to help address any barriers to treatment and suggest options if we are unable to provide treatment as recommended.
- In many cases, treatment will be most successful if any caregivers involved in the child's life are supportive of the child/youth receiving services and will support the child/youth to attend sessions and follow through with treatment plans. **Please include a copy of the separation agreement if available with this form.**
- **We are unable to provide evaluations or recommendations related to custody or access**

We encourage you to ask questions and share information in your appointments. Please take some time to think about what areas you hope to have help with. If you have any questions or difficulty in understanding the information, please email CAMHintake@lhsc.on.ca or call our Intake Office at 519-667-6640.

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Physician Referral

Regarding (Patient Name): _____

Mailing Address _____

Health Card Number (including Version Code): _____

Patient's Current Diagnoses: _____

Patient's Current Medications (including dose):_____

Reason for Referral _____

Name of Referring Physician (Please print): _____

Signature of Referring Physician: _____

Physician Address: _____

_____

_____

Physician Phone #: _____ Physician Fax #: _____

Date of referral: _____

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CAMHCP Intake Questionnaire

For youth: *If you are completing this form on your own, please complete the sections below about yourself.*

Child's Name:_____ **Date of Birth:** _____ **Age:** _____

Form Completed By: _____ **Date:** _____

Relationship to Child: _____

Languages spoken at home: _____

I would identify myself as: ☐ **First Nation** ☐**Métis** ☐ **Inuit**

CUSTODIAL CAREGIVER(S): _____

Relationship to child:_____

Address:_____

City:_____ **Postal Code:**_____

Home Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Which phone number are we able to use if we need to leave you a message regarding your child and our services? _____

If applicable, NON-CUSTODIAL PARENT: _____

Relationship to child:_____

Address:_____

City:_____ **Postal Code:**_____

Home Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Legal/Custody Issues:

Please list the top 3 problems you are currently most concerned about regarding your child. For each problem listed, please rate how much of a problem it is, from **0** "*not at all a problem*" to **10** "*a huge problem.*"

Problem	***Rating***
1.	

Adapted from the Brief Problem Checklist (© 2010 Chorpita, Reise, Weisz) and the Child/Adolescent Psychiatry Screen (© 2004 Jeff Q. Bostic)

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2.	
3.	

Please specify any current/previous agencies that your child has been involved with for mental health issues:

_____

_____

Please specify any current or past mental health diagnoses your child has received:

_____

_____

Are there any close family members that have mental health issues? (Please circle) Yes No

If yes, please complete sections below:

Family Member	**Mental Health Concern**
_____	_____
_____	_____
_____	_____
_____	_____

School: _____ Grade: _____

Functioning:

Do you have any concerns about the following? If yes, please specify:

(1) Academic functioning:

_____

_____

_____

_____

Please estimate your child's current level of functioning at school: (please circle one)

Above grade level At grade level Below grade level

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If your child is performing below grade level, how many grades behind do you estimate your child is academically? _____

(2) Social functioning (e.g., consider both at school and in the community, including difficulties with friendships or social skills):

_____

_____

_____

_____

(3) General developmental concerns (e.g., developmental milestones, physical difficulties, sensory issues):

_____

_____

_____

_____

(4) **Health (e.g., medical problems or complaints about not feeling well, such as headaches, stomach aches; concerns about sleep or eating):**

_____

_____

_____

_____

Current medications:

_____

(5) Risk issues (e.g., suicidal/self-harm behaviours):

Has your child made comments about wanting to die, hurt him/herself, or kill him/herself? (If yes, please provide information about when this started, how often it occurs, and the nature of the comments made)

_____

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_____

_____

_____

_____

_____

_____

Has your child made any attempts to kill him/herself? (please circle) Yes No

If yes, please provide details about the number and nature of past attempts, and when they occurred:

_____

_____

_____

Has your child experienced any major stressors in the past year? (Please circle) Yes No

If yes, please specify:

_____

_____

_____

What impact has the child's difficulties had on your family (e.g., your ability to cope)?

_____

_____

_____

Are there any stressors that are affecting your family's ability to cope (e.g., finances, losses, family conflict, separation or divorce)? (Please circle) Yes No

If yes, please specify:

_____

_____

_____

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Symptom Checklist – Caregiver Version

Please complete the following symptom checklist. For each item below, check the one category that best describes your child ***during the past 6 months*.**

None =	the child never or very rarely exhibits this behavior.
Mild =	the child exhibits this behavior approximately once per week, and few others notice or complain about this behavior.
Moderate =	the child exhibits this behavior at least three times per week, and others notice or comment on this behavior.
Severe =	the child exhibits this behavior almost daily, and multiple others complain about this behavior.
Past =	the child used to have significant problems with this behavior, ***but not during the past 6 months*.**

	None	Mild	Moderate	Severe	Past
CATEGORY A					
1. Worries about or has difficulty separating from parents or primary caregiver					
2. Worries excessively about losing or harm occurring to parents or primary caregiver					
3. Has clear-cut periods of intense fear that peak within 10 minutes					
4. Worries about having anxiety attacks in the future or has changed his/her behavior because of these attacks (e.g., not wanting to go to certain places or on his/her own)					
5. Has excessive, unreasonable fear of a specific object or situation (e.g., storms, needles, insects)					
6. Anxious or shy in many social situations (e.g., meeting new people, talking in class, ordering at a restaurant)					
7. Avoids social and performance situations (e.g., class presentations, eating or writing in front of others, groups of people)					

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8. Has distressing thoughts that he/she cannot get out of his/her mind (e.g., worries about germs)					
	None	**Mild**	**Moderate**	**Severe**	**Past**
9. Needs to perform certain behaviors over and over (e.g., handwashing, doing things a certain number of times, checking or counting things)					
10. Worries excessively about multiple things (e.g., school, family, health)					
11. Worries most days					
12. Finds it hard to stop or control worries					
13. How much do the above anxiety symptoms interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY B					
14. Wets or soils bed or clothing, or goes to the bathroom in inappropriate places					
CATEGORY C					
15. Makes noises, and is often unaware of them					
16. Makes repetitive, quick movements that are hard to control					
17. Pulls out hair repeatedly causing hair loss					
18. Picks at skin repeatedly causing skin damage					
CATEGORY D					
19. Fails to pay close attention to details or makes careless mistakes					
20. Has difficulty maintaining attention during play or school activities					
21. Does not seem to listen when spoken to directly or is easily distracted					
22. Does not follow through on instructions; fails to finish schoolwork/chores					

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23. Is fidgety or squirms in seat, or has difficulty remaining seated					
24. Runs or climbs excessively; is restless					
25. Talks excessively					
26. Blurts out answers before questions have been completed, or interrupts/ intrudes on others					
27. Has difficulty waiting turn					
	None	**Mild**	**Moderate**	**Severe**	**Past**
CATEGORY E					
28. Has periods of abnormally happy/excited or irritable/explosive mood lasting hours or days for no particular reason					
29. Has extended periods of abnormally increased activity or energy					
If you answered none or mild for questions 28 and 29, please skip to next section, Category F.					
30. Believes that he/she has special abilities or powers or can do things that are clearly unrealistic					
31. During these periods of abnormally happy or irritable mood, is much more talkative than usual or seems pressured to keep talking					
32. During these periods of abnormally happy or irritable mood, races from thought to thought or seems like he/she cannot keep up with his/her thoughts					
33. During these periods of abnormally happy or irritable mood, engages in risky activities (e.g., sexually inappropriate behaviors, jumping off heights, overspending)					
34. During these periods of abnormally happy or irritable mood, needs less sleep than usual, yet does not feel tired					

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35. How much do the above mood symptoms interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY F					
36. Shows depressed or irritable mood most of the time for at least 2 weeks					
37. Feels bored or is much less interested in previously enjoyed activities					
38. Shows changes in appetite					
39. Has difficulty falling or staying asleep, or sleeps excessively					
40. Has less energy					
41. Feels worthless or has inappropriate guilt					
42. Thinks about death or dying					
	None	**Mild**	**Moderate**	**Severe**	**Past**
43. Engages in self-harm (e.g., cutting, burning)					
44. Thinks about killing him/herself					
45. Has made attempts to kill him/herself **(circle one)**	**Yes**			**No**	
46. How much do the above mood symptoms interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY G					
47. Uses alcohol or drugs (i.e., recreational drugs or misuse of prescription drugs)					
48. Had bad things happen when under the influence of substances					
49. Has made unsuccessful efforts to stop using alcohol or drugs					
50. How much does alcohol or drug use interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY H					
51. Is excessively worried about gaining weight or thinks he/she is fat, even though not overweight					
52. Engages in behaviors to control weight (e.g., limiting food intake,					

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exercising excessively, vomiting, using laxatives)					
53. Has eating binges (i.e., eats a very large amount of food in a short period)					
CATEGORY I					
54. Bullies, threatens, or intimidates others, or initiates physical fights					
55. Uses weapons that could harm others					
56. Physically cruel to animals					
57. Shoplifts or steals items					
58. Deliberately destroys others' property or sets fires					
59. Breaks curfew or has run away from home overnight					
CATEGORY J					
60. Loses temper					
61. Actively defies or refuses to comply with adult rules					
	None	**Mild**	**Moderate**	**Severe**	**Past**
62. Deliberately annoys others					
63. Blames others for his/her mistakes or misbehavior					
64. Easily annoyed by others					
65. Is spiteful or vindictive					
66. How much do the above behaviors interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY K					
67. Has unusual thoughts that others cannot understand or believe					
68. Hears or sees things that others don't (e.g., hears voices)					
69. How much do the above symptoms interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY L					
70. Has difficulty at school with: reading, writing, math, spelling (Circle all that apply)					
71. Had delayed speech, or has limited language now					
CATEGORY M					

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72. Does not play or interact well with peers					
73. Shows little interest in others, including peers, or prefers to be alone than with others					
74. Uses little body language (e.g., eye contact, gestures, facial expression)					
75. Has difficulty with conversations (e.g., has trouble with back-and-forth conversations or social chit-chat)					
76. Has interests that are overly intense (e.g., spending most of his/her time in interest to the exclusion of other activities) or interests that are unusual (e.g., interest in train schedules, plumbing parts)					
77. Has difficulty with transitions; inflexible around routines or rules					
CATEGORY N					
78. Has experienced an extremely upsetting or traumatic event (e.g., abuse, natural disaster, witnessing someone being badly hurt)	**Yes**			**No**	
If yes, please specify the event and when it occurred:					
79. Has learned about a traumatic event that has happened to a close family member or close friend	**Yes**			**No**	
If yes, please specify the event and when it occurred:					
	None	**Mild**	**Moderate**	**Severe**	**Past**

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80. Has distressing memories about the above event(s)					
81. Repeats elements of the traumatic event(s) in his/her play					
82. Has nightmares since the event(s)					
83. Avoids people, places, or things associated with the above event(s) (can include avoidance of thoughts or feelings, or talking about the event)					
84. Since the event(s), feels numb and/or has been less interested in activities or spending time with others					
85. How much do the above symptoms interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY O					
86. Relationships with others are often intense and unstable					
87. Mood changes easily and dramatically					
88. Chronic feelings of emptiness					
89. Lacks clear sense of self or own identity					
90. Very sensitive to feeling rejected or abandoned by others					
	None	**Mild**	**Moderate**	**Severe**	**Past**
91. Engages in impulsive or reckless behaviors (e.g., involving drugs, money, sex, self-harm)					
92. How much do the above symptoms interfere with his/her day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**

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Child and Adolescent Mental Health Care Program (CAMHCP)
Consent Form for E-mail Distribution of Resources

Dear Family,

Would you be interested in receiving e-mail communications from us about resources available either within our program or in the community that may be of assistance to your family while you are waiting for services? The e-mail will be sent from CAMHCP@lhsc.on.ca, so others who inadvertently see this e-mail may recognize this as being sent from our program and/or the hospital. Although your name will be on a distribution list with other families also waiting for services, your e-mail address will not be visible to others on the list. You can contact us by phone at (519) 667-6640 or by responding to the e-mail if you wish to be removed from the e-mail distribution list.

Although general information about available resources will be shared via e-mail, please note that no specific information about your child or his or her care will be communicated by e-mail. Given that e-mails are not a secure form of communication, we also ask that any questions or concerns you have about your child's care while you are waiting for services be directed by phone to our Intake department at (519) 667-6640 and not via e-mail. Unfortunately, we will be unable to read or respond to any questions or concerns specific to your child's care received via e-mail.

Would you be interested in being added to our e-mail distribution list? YES NO

E-mail address: _____

Patient's name: _____

_____ _____
Name of family member providing consent Signature

_____
Date

Thank you. Please send this completed form to the person submitting this referral on your behalf (e.g., family physician, mental health professional, school personnel)

Symptom Checklist – Youth Version (for ages 12 years and older)

Your Name:_____

For each item below, check the one category that best describes you ***during the past 6 months*.**

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None =	I never or very rarely exhibit this behavior.
Mild =	I exhibit this behavior approximately once per week, and few others notice or complain about this behavior.
Moderate =	I exhibit this behavior at least three times per week, and others notice or comment on this behavior.
Severe =	I exhibit this behavior almost daily, and multiple others complain about this behavior.
Past =	I used to have significant problems with this behavior, ***but not during the past 6 months*.**

	None	Mild	Moderate	Severe	Past
CATEGORY A					
1. I worry about, or have difficulty, separating from my parents or primary caregiver					
2. I worry excessively about losing, or harm occurring to, my parents or primary caregiver					
3. I have clear-cut periods of intense fear that peak within 10 minutes					
4. I worry about having anxiety attacks in the future or have changed my behavior because of these attacks (e.g., not wanting to go to certain places or on my own)					
5. I have excessive, unreasonable fear of a specific object or situation (e.g., storms, needles, insects)					
6. I am anxious or shy in many social situations (e.g., meeting new people, talking in class, ordering at a restaurant)					
7. I avoid social and performance situations (e.g., class presentations, eating or writing in front of others, groups of people)					
8. I have distressing thoughts that I cannot get out of my mind (e.g., worries about germs)					
	None	**Mild**	**Moderate**	**Severe**	**Past**
9. I need to perform certain behaviors over and over (e.g., handwashing,					

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doing things a certain number of times, checking or counting things)					
10. I worry excessively about multiple things (e.g., school, family, health)					
11. I worry most days					
12. I find it hard to stop or control my worries					
13. How much do the above anxiety symptoms interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY B					
14. I wet or soil the bed or clothing, or go to the bathroom in inappropriate places					
CATEGORY C					
15. I make noises, and I am often unaware of them					
16. I make repetitive quick movements that are hard to control					
17. I pull out my hair repeatedly causing hair loss					
18. I pick at my skin repeatedly causing skin damage					
CATEGORY D					
19. I fail to pay close attention to details or make careless mistakes					
20. I have difficulty maintaining attention during play or school activities					
21. I have difficulty listening when spoken to directly or am easily distracted					
22. I do not follow through on instructions; I fail to finish my schoolwork/chores					
23. I am fidgety or squirm in my seat, or have difficulty remaining seated					
24. I run or climb excessively; I am restless					
25. I talk excessively					
26. I blurt out answers before questions have been completed, or interrupt/ intrude on others					
27. I have difficulty waiting my turn					

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	None	Mild	Moderate	Severe	Past
CATEGORY E					
28. I have periods of abnormally happy/excited or irritable/explosive mood lasting hours or days for no particular reason					
29. I have extended periods of abnormally increased activity or energy					
If you answered none or mild for questions 28 and 29, please skip to next section, Category F.					
30. I believe that I have special abilities or powers or can do things that are clearly unrealistic					
31. During these periods of abnormally happy or irritable mood, I am much more talkative than usual or I feel pressured to keep talking					
32. During these periods of abnormally happy or irritable mood, my mind races from thought to thought, or it seems like I cannot keep up with my thoughts					
33. During these periods of abnormally happy or irritable mood, I engage in risky activities (e.g., sexually inappropriate behaviors, jumping off heights, overspending)					
34. During these periods of abnormally happy or irritable mood, I need less sleep than usual, yet I do not feel tired					
35. How much do the above mood symptoms interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY F					
36. I have experienced depressed or irritable mood most of the time for at least 2 weeks					
37. I have been feeling bored or much less interested in previously enjoyed activities					
38. I have experienced a change in appetite					

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39. I have experienced difficulty falling or staying asleep, or have been sleeping excessively					
	None	**Mild**	**Moderate**	**Severe**	**Past**
40. I have experienced loss of energy					
41. I have experienced feelings of worthlessness or inappropriate guilt					
42. I think about death or dying					
43. I engage in self-harm (e.g., cutting, burning)					
44. I think about killing myself					
45. I have made attempts to kill myself **(circle one)**	**Yes**			**No**	
46. How much do the above mood symptoms interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY G					
47. I use alcohol or drugs (i.e., recreational drugs or misuse of prescription drugs)					
48. I have had bad things happen when under the influence of substances					
49. I have made unsuccessful efforts to stop using alcohol or drugs					
50. How much does alcohol or drug use interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY H					
51. I am excessively worried about gaining weight or think I am fat, even though others tell me that I am not overweight					
52. I engage in behaviors to control my weight (e.g., limiting food intake, exercising excessively, vomiting, using laxatives)					
53. I have eating binges (i.e., eating a very large amount of food in a short period)					
CATEGORY I					

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54. I bully, threaten, or intimidate others, or initiate physical fights					
55. I use weapons that could harm others					
56. I am physically cruel to animals					
57. I shoplift or steal items					
58. I deliberately destroy others' property or set fires					
	None	**Mild**	**Moderate**	**Severe**	**Past**
59. I break curfew or have run away from home overnight					
CATEGORY J					
60. I lose my temper					
61. I actively defy or refuse to comply with adult rules					
62. I deliberately annoy others					
63. I blame others for my mistakes or misbehavior					
64. I am easily annoyed by others					
65. I am spiteful or vindictive					
66. How much do the above behaviors interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY K					
67. I have unusual thoughts that others cannot understand or believe					
68. I hear or see things that others don't (e.g., hearing voices)					
69. How much do the above symptoms interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY L					
70. I have difficulty at school with: reading, writing, math, spelling (Circle all that apply)					
71. I have delayed speech, or have limited language now					
CATEGORY M					
72. I do not play or interact well with my peers					
73. I have little interest in others, including peers, or I prefer to be alone than with others					

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74. I use little body language (e.g., eye contact, gestures, facial expression)					
75. I have difficulty with conversations (e.g., trouble with back-and-forth conversations or social chit-chat)					
76. I have interests that are overly intense (e.g., spending most of my time in interest to the exclusion of other activities) or interests that are unusual (e.g., interest in train schedules, plumbing parts)					
77. I have difficulty with transitions; I am inflexible around routines/rules					
CATEGORY N					
78. I have experienced an extremely upsetting or traumatic event (e.g., abuse, natural disaster, witnessing someone being badly hurt)	**Yes**		**No**		
If yes, please specify the event and when it occurred:					
79. I learned about a traumatic event that happened to a close family member or close friend	**Yes**		**No**		
If yes, please specify the event and when it occurred:					
	None	**Mild**	**Moderate**	**Severe**	**Past**
80. I have distressing memories about the above event(s)					
81. I have had nightmares since the event(s)					
82. I sometimes act out parts of the traumatic event(s) when I am playing					
83. I avoid people, places, or things that remind me of the above event(s)					

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(can include not talking about the event(s), or trying to put out of your mind any thoughts or feelings related to the event(s))					
84. Since the event(s), I feel numb and/or have been less interested in activities or spending time with others					
85. How much do the above symptoms interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**
CATEGORY O					
86. My relationships with others are often intense and unstable					
87. My mood changes easily and dramatically					
	None	**Mild**	**Moderate**	**Severe**	**Past**
88. I feel empty					
89. I feel confused about who I am or about my identity					
90. I am very sensitive to feeling rejected or abandoned by others					
91. I act without thinking or act recklessly (e.g., involving drugs, money, sex, self-harm)					
92. How much do the above symptoms interfere with your day-to-day functioning? (circle one)	**Not at all**	**Slightly**	**Somewhat**	**Moderately**	**Extremely**

Thank you. Please send this completed form to the person submitting this referral on your behalf (e.g., family physician, mental health professional, school personnel)

Adapted from the Brief Problem Checklist (© 2010 Chorpita, Reise, Weisz) and the Child/Adolescent Psychiatry Screen (© 2004 Jeff Q. Bostic)