WESTERN MICHIGAN UNIVERSITY
College of Health and Human Services
Resiliency Center for
Families and Children

Resiliency Center for Families and Children
Western Michigan University
Unified Clinics
1000 Oakland Dr.
Kalamazoo, MI 49008
Phone: (269) 387-7073
Fax: (269) 387-7026
E-mail: chhs-rcat@wmich.edu

# Resiliency Center for Families and Children
# Trauma Assessment Referral Form

**Child's Name**: _____

**Date of Birth:**_____ **Child's age:**_____

**Sex assigned at birth:** ☐ Male ☐ Female ☐ Intersex

*We care about understanding who you are. If you don't see yourself reflected in the categories provided below, please use the text boxes to write in your answer*

**Gender Identity:** ☐ Male ☐ Female ☐ Non-binary / Gender Nonconforming
☐ Questioning / Not sure ☐ Prefer not to say
☐ Not listed. Please describe: _____

**Ethnicity:** ☐ Hispanic or Latino/a ☐ non-Hispanic or Latino/a

**Race:** (if multiracial please check all that apply)

☐ American Indian or Alaska Native ☐ White / Caucasian
☐ Asian ☐ Native Hawaiian / Pacific Islander
☐ Black or African American ☐ Prefer not to say
☐ Another Race Not Listed. Please describe: _____

**Primary language(s) spoken in the home**:

☐ English ☐ Other Language(s). Please describe: _____

***Primary Caregiver(s) Information***

Name(s): _____

Relationship to child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

***Additional Caregiver(s) Information***

Name(s): _____

Relationship to child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

***Contact Information of Referring Person***

Referring Person: _____

Agency: _____

Phone Number**:** _____ Email Address: _____

***Reason for Referral:*** Please include the following information: any traumatic experiences or exposures, foster care placements or CPS involvement, impact that the experiences have had on the child, concerns regarding the child's mental health, ability to learn, developmental concerns, concerns regarding Autism, Fetal Alcohol Syndrome, or any other diagnoses, and any other information that you feel is helpful to share.

**What are the current custody arrangements for the child?**

☐Full custody ☐Joint legal, full physical custody

☐Joint legal and physical custody ☐Guardianship

☐Other – please explain: _____

**Are there any plans to request change in the custody arrangements?**

☐Yes ☐ No

If yes, please explain:

**Is the child adopted?** ☐Yes ☐ No

If yes, when was the adoption finalized? Please include any other necessary information.

**Is this child or members of the family currently involved with Child Protective Services or the Foster Care System?**

☐Yes ☐ No

If yes, please explain:

**Is this child involved with the Juvenile Justice System?**

☐Yes ☐No

If yes, please explain:

***Insurance Information***

Insurance Name/Company_____

Member ID # _____

Group # _____

Subscriber Name and Date of Birth _____

Relationship to Child: _____

Claim information phone number on the back of card: _____

***Medical Information***

**Does the child have a Primary Care Provider**? ☐Yes ☐ No

Provider's Name**:** _____

Provider's Practice: _____

Provider's Phone Number: _____

**Are there any medical concerns or diagnoses for the child?** ☐Yes ☐ No

If yes, please explain:

**Is the child currently taking any medications?** ☐Yes ☐ No
If yes, please list the medications and the dosages:

**Are there concerns for possible Fetal Alcohol Exposure or Prenatal Drug Exposure?**

☐Yes ☐No

***Additional Information***

**What school does the child attend?** _____

**Does the child have an IEP or 504 plan?** ☐Yes ☐ No

**Are there other children in the home?** ☐Yes ☐ No

**If yes, please complete the following section:**

| **Other Children's Names** | **Age** | **Gender** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Does the child currently receive additional services (Early On, Special Education, speech and language services, occupational therapy.)?** ☐Yes ☐ No

If yes, please list services and providers of the child:

_____

_____

_____

_____

_____

**Is the child working with a mental health therapist?** ☐Yes ☐ No

Therapist Name: _____

Agency: _____

Phone: _____ Email: _____

**Is there any additional information that you would like the Resiliency Center to know?**

**Please complete the attached Trauma Symptom Checklist (Henry, Black-Pond & Richardson, 2010) by marking known or suspected trauma exposure, as well as other concerns the child may present with. For children 0-5 years old, please complete the section starting on page 6. For children 6 and up, please complete the section starting on page 7:**

## ***Children 0-5:***

| **Known or Suspected Trauma Exposure:** | | | |
|---|---|---|---|
| | Physical abuse | | Exposure to drug activity (aside from parental use) |
| | Neglectful home environment | | Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy |
| | Emotional abuse | | Lengthy or multiple separations from parent |
| | Exposure to domestic violence | | Placement outside of the home (kinship care, foster care, residential) |
| | Exposure to other chronic violence | | Loss of significant people, places, etc. |
| | Sexual abuse or exposure | | Frequent/multiple moves; homelessness |
| | Parental substance abuse | | Other: |
| | Impaired parenting (mental illness) | | |

| **Behavioral Signs of Trauma:** | | | |
|---|---|---|---|
| | Aggression towards self; self-harm | | Sexual behaviors not typical for age |
| | Excessive aggression or violence towards others | | Difficulty sleeping, eating, or toileting |
| | Explosive behavior (going form 0-100 instantly) | | Social/developmental delays in comparison to peers |
| | Hyperactivity, distractibility, inattention | | Repetitive violent and/or sexual play (or maltreatment themes) |
| | Excessively shy | | Unpredictable/sudden changes in behavior (i.e., attention, play) |
| | Oppositional and/or defiant behavior | | Other: |

| **Emotional Signs of Trauma:** | | | |
|---|---|---|---|
| | Excessive mood swings | | Flat affect, very withdrawn, seems emotionally numb or “zoned out” |
| | Frequent, intense anger | | Other: |
| | Chronic sadness, doesn’t seem to enjoy any activities, depressed mood | | |

| **Relational/Attachment Difficulties:** | | | |
|---|---|---|---|
| | Lack of eye contact or avoids eye contact | | Doesn’t reciprocate when hugged, smiled at, spoken to |
| | Sad or empty eyed appearance | | Doesn’t seek comfort when hurt or frightened; shakes it off, or doesn’t seem to feel it |
| | Overly friendly with strangers (lack of appropriate stranger anxiety) | | Has difficulty in preschool or daycare |
| | Vacillation between clinginess and disengagement and/or aggression | | Other: |

## ***Children 6+***

| **Known or Suspected Trauma Exposure:** | | | |
|---|---|---|---|
| | Physical abuse | | Exposure to drug activity (aside from parental use) |
| | Neglectful home environment | | Prenatal exposure to alcohol/drugs or maternal stress during pregnancy |
| | Emotional abuse | | Lengthy or multiple separations from a parent |
| | Exposure to domestic violence | | Placement outside of the home (kinship care, foster care, residential) |
| | Exposure to other chronic violence | | Loss of significant people, places, etc. |
| | Sexual abuse or exposure | | Frequent/multiple moves; homelessness |
| | Parental substance abuse | | Other: |
| | Impaired parenting (mental illness) | | |

| **Behavioral Signs of Trauma:** | | | |
|---|---|---|---|
| | Aggression towards self; self-harm | | Oppositional/defiant behavior |
| | Excessive aggression or violence towards others | | Sexual behaviors not typical for age |
| | Explosive behavior (going form 0-100 instantly) | | Difficulty sleeping, eating, or toileting |
| | Hyperactivity, distractibility, inattention | | Social/developmental delays in comparison to peers |
| | Excessively shy | | Other: |

| **Emotional Signs of Trauma:** | | | |
|---|---|---|---|
| | Excessive mood swings | | Flat affect, very withdrawn, seems emotionally numb or “zoned out” |
| | Frequent, intense anger | | Other: |
| | Chronic sadness, does not seem to enjoy any activities, depressed mood | | |

| **Difficulties in School:** | | | |
|---|---|---|---|
| | Low or failing grades | | Difficulty with authority/frequent behavior referrals |
| | Attention and/or memory problems | | Other: |
| | Sudden changes in performance | | |

| **Relational/Attachment Difficulties:** | | | |
|---|---|---|---|
| | Lack of eye contact or avoids eye contact | | Does not seek adult help when hurt of frightened |
| | Lack of appropriate boundaries in relationships | | Other: |

## ***Well-being Survey***

**TO BE ANSWERED BY THE PARENT/CAREGIVER OF A CHILD/TEEN (2 to 12 years old)**

For each item, please mark the box for "Not True", "Somewhat True", or "Certainly True". It would help us if you answered all the questions as best you can even if you are not absolutely certain. Please, give your answers based on the child's behavior over the *last 6 months or this school year*.

| | Not True | Somewhat True | Certainly True | Does not apply |
|---|---|---|---|---|
| 1. Considerate of other people's feelings | | | | |
| 2. Restless, overactive, cannot stay still for long | | | | |
| 3. Often complains of headaches, stomach-aches, or sickness | | | | |
| 4. Shares readily with other children, e.g., toys, treats, pencils | | | | |
| 5. Often loses temper | | | | |
| 6. Rather solitary, prefers to play alone | | | | |
| 7. Generally well behaved, usually does what adults request | | | | |
| 8. Many worries or often seems worried | | | | |
| 9. Helpful if someone is hurt, upset, or feeling ill | | | | |
| 10. Constantly fidgeting or squirming | | | | |
| 11. Has at least one good friend | | | | |
| 12. Often fights with other children or bullies them | | | | |
| 13. Often unhappy, depressed, or tearful | | | | |
| 14. Generally liked by other children | | | | |
| 15. Easily distracted, concentration wanders | | | | |
| 16. Nervous or clingy in new situations, easily loses confidence | | | | |
| 17. Kind to younger children | | | | |
| 18. Often lies or cheats | | | | |
| 19. Picked on or bullied by other children | | | | |
| 20. Often offers to help others (parents, teachers, other children) | | | | |
| 21. Thinks things out before acting | | | | |
| 22. Steals from home, school, or elsewhere | | | | |
| 23. Gets along better with adults than with other children | | | | |
| 24. Many fears, easily scared | | | | |
| 25. Good attention span, sees work through to the end | | | | |

**Please send any documentation that you believe would be beneficial for the Resiliency Center with this referral (school plans, court documents, medical documents, any other reports/testing for the child, etc.). Referrals can be emailed to chhs-rcat@wmich.edu. If you have any questions regarding this referral or services offered at the Resiliency Center, please call (269) 387-7073.**

**WMU Unified Clinics**

**Resiliency Center for Families and Children**

Patient Referral

**Patient Name:** _____ **DOB:** _____/_____/_____

**Address:** _____ **Phone:** _____

**Referring Physician:** _____

**Name of Practice:** _____

**Phone:**_____-_____-_____ **Fax:** _____-_____-_____

**Date of last physical:** _____/_____/_____

***A summery of the client's last office visit or clinical services should be included with the occupational therapy script. Referral information can be faxed to the WMU Resiliency Center 269-293-3357 or emailed to chhs-rcat@ wmich.edu.***

Please Address:

**Diagnosis and ICD-10 Code:**

**OT Evaluation and Treatment**

*With my signature, I authorize the above individual for outpatient occupational therapy evaluation and treatment.*

**Physician's Signature:** _____ **Date:** _____/_____/_____

**Printed Name:** _____

Western Michigan University Resiliency Center
Unified Clinics / College of Health and Human Services 1000 Oakland Drive
Kalamazoo, MI 49008-5361
P:(269) 387-7073 F: (269) 387-7026
Email: chhs-rcat@ wmich.edu