Child Health and Development Institute of Connecticut, Inc.

DCF CONNECTICUT

TF-CBT Follow Up Forms (Monthly, Periodic, & Discharge)

English

Required Forms

1. TF-CBT Monthly Session Form ☐

2. Child's Behavior & Functioning*
   Ohio- Caregiver Report (child 5+) ☐
   Ohio- Child Report (child 12+) ☐

3. Chosen Assessment(s) specific to TF-CBT* ☐

Note: *The recommended ongoing assessment for TF-CBT is an age appropriate measure of trauma symptoms. We suggest the CPSS (7+) or YCPC 5 (under 7). These assessments are included in the packet.*

Alternate or additional measures can be used based on clinical judgment of primary symptom area targeted by treatment

4. Satisfaction Questionnaire (caregiver or child)* ☐

5. Client Discharge Face Sheet ☐

***Required at periodic and discharge**

TF-CBT Monthly Session Form

VALIDATION REQUIREMENTS AND SYMBOLS EXPLAINED

! This symbol means the field is one of the minimum fields that must be filled out to save the record. No data will be saved unless these fields are completed.

* This symbol means the field is a required field in order to save the record as completed. Although you can save the record, the system does not consider the record to be completed unless ALL of these fields are completed.

Data Entry Person: Greyed-out fields are pulled in from the completed Client Face Sheet-Intake, so you won't have to enter them again here

Direct Service Provider User Information

Clinician First Name:		**Clinician Last Name:**	
Project Name:			

Child Information

First Initial of First Name:		**First Initial of Last Name:**		**Date of Birth:**	

Child Identification Codes

Provider Client ID:		**PSDCRS ID:**	

Session Information

Was there a visit this month? (Select one)	❒	**Yes**	❒	**No**

Treatment Components

Please check all Components Used this month:	❒	Using Measures (administer or share results)	❒	Relaxation	❒	Trauma Narrative Completed
	❒	Case Management (assist with basic needs, collateral contacts with school/DCF, etc.)	❒	Affective Expression	❒	In Vivo Exposure
	❒	Psychoeducation	❒	Cognitive Coping	❒	Conjoint Session (prepping or sharing trauma narratives w/caregiver)
	❒	Parenting Skills	❒	Trauma Narrative	❒	Enhancing Safety

Collaboration

During this month, did you communicate with the child's:	❒	DCF Worker	❒	Probation officer	❒	Physician
	❒	School	❒	Other		
Collaboration Notes:						

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TF-CBT Monthly Session Form

Functioning						
Compared to the child's condition at the start of TF-CBT, this child's condition is:	❒	Very much improved since the initiation of treatment	❒	Much Improved	❒	Minimally improved
	❒	No change from baseline (the initiation of treatment)	❒	Minimally worse	❒	Much Worse
	❒	Very much worse since the initiation of treatment				
Session Fidelity Checklist						
Session Structure						
Prior to how many sessions this month did you prepare materials or a session plan?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month was homework assigned or reviewed?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month were COWS saved for the end of the session?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		
During how many sessions this month did the child and/or caregiver practice/demonstrate skill(s) in session (behavior rehearsal)?	❒	None (0%)	❒	Some (34-66%)	❒	All (100%)
	❒	A few (1-33%)	❒	Most (67-99%)		

12/5/2019

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

P

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

January 2000 (Parent-1)

Response Scale for OHIO Problem Scale

0	1	2	3	4	5
Not at all	Once or twice	Several times	Often	Most of the time	All of the time

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Ohio Youth Problem and Functioning Scales (Caregiver: English)

Parent Rating – Short Form continued

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

 January 2000 (Parent-2)

(Add ratings together) Total _____

Response Scale for OHIO Functioning Scale

0	1	2	3	4
Extreme troubles	Quite a few troubles	Some troubles	OK	Doing very well

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Y

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem and Functioning Scales (Child: English)

Youth Rating – Short Form (Ages 12-18)

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

January 2000 (Youth-1)

Response Scale for OHIO Problem Scale

0	1	2	3	4	5
Not at all	Once or twice	Several times	Often	Most of the time	All of the time

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Ohio Youth Problem and Functioning Scales (Child: English)

Youth Rating – Short Form (Ages 12-18) continued

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

January 2000 (Youth-1)

Response Scale for OHIO Functioning Scale

0	1	2	3	4
Extreme troubles	Quite a few troubles	Some troubles	OK	Doing very well

Client Initials: _____ Client ID: _____ Date of Completion: ___/___/___

CPSS – V Caregiver Report (English)

These questions ask about how your child feels about the upsetting things you described. Choose the number (0-4) that best describes how often that problem has bothered him/ her **IN THE LAST MONTH.**

0	1	2	3	4
Not at all	Once a week or less / a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week / almost always

1.	Having upsetting thoughts or pictures about it that came into your child's head when he/she didn't want them to	0	1	2	3	4
2.	Having bad dreams or nightmares	0	1	2	3	4
3.	Acting or feeling as if it was happening again (seeing or hearing something and feeling as if he/she was there again)	0	1	2	3	4
4.	Feeling upset when he/she remember what happened (for example, feeling scared, angry, sad, guilty, confused)	0	1	2	3	4
5.	Having feelings in his/her body when he/she remembers what happened (for example, sweating, heart beating fast, stomach or head hurting)	0	1	2	3	4
6.	Trying not to think about it or have feelings about it	0	1	2	3	4
7.	Trying to stay away from anything that remind him/her of what happened (for example, people, places, or conversations about it)	0	1	2	3	4
8.	Not being able to remember an important part of what happened	0	1	2	3	4
9.	Having bad thoughts about himself/herself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")	0	1	2	3	4
10.	Thinking that what happened is his/her fault (for example, "I should have known better", "I shouldn't have done that", "I deserved it")	0	1	2	3	4
11.	Having strong bad feelings (like fear, anger, guilt, or shame)	0	1	2	3	4
12.	Having much less interest in doing things he/she used to do	0	1	2	3	4
13.	Not feeling close to his/her friends or family or not wanting to be around them	0	1	2	3	4
14.	Trouble having good feelings (like happiness or love) or trouble having any feelings at all	0	1	2	3	4
15.	Getting angry easily (for example, yelling, hitting others, throwing things)	0	1	2	3	4
16.	Doing things that might hurt himself/herself (for example, taking drugs, drinking alcohol, running away, cutting himself/herself)	0	1	2	3	4
17.	Being very careful or on the lookout for danger (for example, checking to see who is around him/her and what is around him/her)	0	1	2	3	4
18.	Being jumpy or easily scared (for example, when someone walks up behind him/her, when he/she hear a loud noise)	0	1	2	3	4
19.	Having trouble paying attention (for example, losing track of a story on TV, forgetting what he/she read, unable to pay attention in class)	0	1	2	3	4
20.	Having trouble falling or staying asleep	0	1	2	3	4

Adapted from Foa, E.B.; Johnson, K.M., & Treadwell, K.R.H. The Child PTSD symptom Scale for DSM 5 (2014)

Child PTSD Symptom Scale

0	1	2	3	4
Not at all	Once a week or less/ a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week/almost always

Client Initials: _____ Client ID: _____ Date of Completion: ___/___/___

CPSS – V Child Report (English)

These questions ask about how you feel about the upsetting things you described. Choose the number (0-4) that best describes how often that problem has bothered you **IN THE LAST MONTH.**

0	1	2	3	4
Not at all	Once a week or less / a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week / almost always

1.	Having upsetting thoughts or pictures about it that came into your head when you didn't want them to	0	1	2	3	4
2.	Having bad dreams or nightmares	0	1	2	3	4
3.	Acting or feeling as if it was happening again (seeing or hearing something and feeling as if you are there again)	0	1	2	3	4
4.	Feeling upset when you remember what happened (for example, feeling scared, angry, sad, guilty, confused)	0	1	2	3	4
5.	Having feelings in your body when you remember what happened (for example, sweating, heart beating fast, stomach or head hurting)	0	1	2	3	4
6.	Trying not to think about it or have feelings about it	0	1	2	3	4
7.	Trying to stay away from anything that reminds you of what happened (for example, people, places, or conversations about it)	0	1	2	3	4
8.	Not being able to remember an important part of what happened	0	1	2	3	4
9.	Having bad thoughts about yourself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")	0	1	2	3	4
10.	Thinking that what happened is your fault (for example, "I should have known better", "I shouldn't have done that", "I deserved it")	0	1	2	3	4
11.	Having strong bad feelings (like fear, anger, guilt, or shame)	0	1	2	3	4
12.	Having much less interest in doing things you used to do	0	1	2	3	4
13.	Not feeling close to your friends or family or not wanting to be around them	0	1	2	3	4
14.	Trouble having good feelings (like happiness or love) or trouble having any feelings at all	0	1	2	3	4
15.	Getting angry easily (for example, yelling, hitting others, throwing things)	0	1	2	3	4
16.	Doing things that might hurt yourself (for example, taking drugs, drinking alcohol, running away, cutting yourself)	0	1	2	3	4
17.	Being very careful or on the lookout for danger (for example, checking to see who is around you and what is around you)	0	1	2	3	4
18.	Being jumpy or easily scared (for example, when someone walks up behind you, when you hear a loud noise)	0	1	2	3	4
19.	Having trouble paying attention (for example, losing track of a story on TV, forgetting what you read, unable to pay attention in class)	0	1	2	3	4
20.	Having trouble falling or staying asleep	0	1	2	3	4

Adapted from Foa, E.B.; Johnson, K.M., & Treadwell, K.R.H. The Child PTSD Symptom Scale for DSM 5 (2014)

Child PTSD Symptom Scale

0	1	2	3	4
Not at all	Once a week or less/ a little	2 to 3 times a week / somewhat	4 to 5 times a week / a lot	6 or more times a week/almost always

Below is a list of symptoms that children can have after life-threatening events.
When you think of ALL the life-threatening traumatic events from the first page, circle the number below (0-4) that best describes how often the symptom has bothered you in the LAST 2 WEEKS.

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

14. Does your child have intrusive memories of the trauma? Does s/he bring it up on his/her own?	0	1	2	3	4
15. Does your child re-enact the trauma in play with dolls or toys? This would be scenes that look just like the trauma. Or does s/he act it out by him/herself or with other kids?	0	1	2	3	4
16. Is your child having more nightmares since the trauma(s) occurred?	0	1	2	3	4
17. Did night terrors start or get worse after the trauma(s)? Night terrors are different from nightmares: in night terrors a child usually screams in their sleep, they don't wake up, and they don't remember it the next day.	0	1	2	3	4
18. Does your child act like the traumatic event is happening to him/her again, even when it isn't? This is where a child is acting like they are back in the traumatic event and aren't in touch with reality. This is a pretty obvious thing when it happens.	0	1	2	3	4
19. Since the trauma(s) has s/he had episodes when s/he seems to freeze? You may have tried to snap him/her out of it but s/he was unresponsive.	0	1	2	3	4
20. Does s/he get upset when exposed to reminders of the event(s)?	0	1	2	3	4

For example, a child who was in a car wreck might be nervous while riding in a car now.
Or, a child who was in a hurricane might be nervous when it is raining.
Or, a child who saw domestic violence might be nervous when other people argue.
Or, a girl who was sexually abused might be nervous when someone touches her.

21. Does your child get physically distressed when exposed to reminders? Like heart racing, shaking hands, sweaty, short of breath, or sick to his/her stomach?"	0	1	2	3	4

Think of the same type of examples as in #20.

22. Does your child show persistent negative emotions (fear, guilt, sadness, shame, confusion) that are <u>not</u> triggered by exposure to reminders of the event as in #20?	0	1	2	3	4

PLEASE CONTINUE ON NEXT PAGE…..

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

23. Does your child try to avoid people or conversations that might remind him/her of the trauma(s)? For example, if other people talk about what happened, does s/he walk away or change the topic?	0	1	2	3	4
24. Does your child try to avoid things or places that remind him/her of the trauma(s)? For example, a child who was in a car wreck might try to avoid getting into a car. Or, a child who was in a flood might tell you not to drive over a bridge. Or, a child who saw domestic violence might be nervous to go in the house where it occurred. Or, a girl who was sexually abused might be nervous about going to bed because that's where she was abused before.	0	1	2	3	4
25. Has s/he lost interest in doing things that s/he used to like to do since the trauma(s)?	0	1	2	3	4
26. Since the trauma(s) has your child become more distant and withdrawn from family members, relatives, or friends?	0	1	2	3	4
27. Since the trauma(s), does your child show a restricted range of positive emotions on his/her face compared to before?	0	1	2	3	4
28. Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma(s)?	0	1	2	3	4
29. Has s/he been more "on the alert" for bad things to happen? For example, does s/he look around for danger?	0	1	2	3	4
30. Does your child startle more easily than before the trauma(s)? For example, if there's a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?	0	1	2	3	4
31. Has your child had more trouble concentrating since the trauma(s)?	0	1	2	3	4
32. Has s/he had a hard time falling asleep or staying asleep since the trauma(s)?	0	1	2	3	4
33. Has your child become more physically aggressive since the trauma(s)? Like hitting, kicking, biting, or breaking things.	0	1	2	3	4
34. Has s/he become more clingy to you since the trauma(s)?	0	1	2	3	4

PLEASE CONTINUE ON NEXT PAGE…..

0	1	2	3	4
Not at all	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/ almost always	Everyday

35. Since the trauma(s), has your child lost previously acquired skills? 0 1 2 3 4
    For example, lost toilet training?
    Or, lost language skills?
    Or, lost motor skills working snaps, buttons, or zippers?

36. Since the trauma(s), has your child developed any new fears about things that don't seem related to the trauma(s)? 0 1 2 3 4
    What about going to the bathroom alone?
    Or, being afraid of the dark?

FUNCTIONAL IMPAIRMENT

Do the symptoms that you endorsed above get in the way of your child's ability to function in the following areas?

0	1	2	3	4
Hardly ever/ none	Some of the time	About half the days	More than half the days	Everyday

37. Do (symptoms) substantially "get in the way" of how s/he gets along with you, interfere in your relationship, or make you feel upset or annoyed? 0 1 2 3 4

38. Do these (symptoms) "get in the way" of how s/he gets along with brothers or sisters, and make them feel upset or annoyed? 0 1 2 3 4

39. Do these (symptoms) "get in the way" with the teacher or the class more than average? 0 1 2 3 4

40. Do (symptoms) "get in the way" of how s/he gets along with friends at all – at daycare, school, or in your neighborhood? 0 1 2 3 4

41. Do (symptoms) make it harder for you to take him/her out in public than it would be with an average child?" 0 1 2 3 4
    Is it harder to go out with your child to places like the grocery store?
    Or to a restaurant?

42. Do you think that these behaviors cause your child to feel upset? 0 1 2 3 4

version 12/9/13

SCORING

The Traumatic Events page (items 1-13) is important to include before administering the symptom portion because it is important to know all of the traumatic events one has experienced that may be linked to symptoms. This page provides a systematic menu to facilitate recall of all events.

Symptoms are scored for totality of events in contrast to many other checklists that rate for only one event.

Items 14-36 are PTSD symptom items. Sum the scores from items 14-36. The suggested cutoff is based on a "probable diagnosis" of PTSD, which is a score of 26 or more for items 14-36. When youth have scores lower than 26 they can still have symptoms and functional impairment that would benefit from treatment.

(Items 37-42 are functional impairment items. These can summed for an impairment score but are not used for the PTSD symptoms score.)

	Items	Probable Diagnosis Cutoff
PTSD Symptoms	14-36	$\geq$ 26
Functional impairment	37-42	$\geq$ 4

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Satisfaction Questionnaire

P

Parent Rating –OHIO SATISFACTION SCALE (English)

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. To what degree have you been included in the treatment planning process for your child?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____

Client Initials: _____ Client ID: _____ Date of Completion: ___/____/____

Satisfaction Questionnaire

Y

Youth Rating – OHIO SATISFACTION SCALE

Form Completed By: ☐ Caregiver ☐ Child ☐ Other: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?

1. Extremely satisfied
2. Moderately satisfied
3. Somewhat satisfied
4. Somewhat dissatisfied
5. Moderately dissatisfied
6. Extremely dissatisfied

2. How much are you included in deciding your treatment?

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

3. Mental health workers involved in my case listen to me and know what I want.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

4. I have a lot of say about what happens in my treatment.

1. A great deal
2. Quite a bit
3. Moderately
4. Somewhat
5. A little
6. Not at all

Total: _____

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Discharge Facesheet (MATCH-ADTC & TF-CBT)

! This symbol means the field is one of the minimum fields that must be filled out to save the record. No data will be saved unless these fields are completed.

* This symbol means the field is a required field in order to save the record as completed. Although you can save the record, the system does not consider the record to be completed unless ALL of these fields are completed.

Data Entry Person: Greyed-out fields are pulled in from the completed Client Face Sheet-Intake, so you won't have to enter them again here

Direct Service Provider User Information

Clinician First Name:		**Clinician Last Name:**	
Project:		**Treatment Model Site:**	

Child Information

Grade (current): *	

Child Identification Codes

Provider's Unique Client ID:			**PSDCRS ID:**		
Which EBP?	❒	MATCH-ADTC	❒	TF-CBT	

Discharge Information

How many visits during this case:		**Discharge Date:** * _____/_____/_____
% of the total time spent with the child ONLY during this case:		**The total time spent for these three % questions should equal 100%**
% of the total time spent with the caregiver ONLY during this case:		**The total time spent for these three % questions should equal 100%**
% of the total time spent with the child and caregiver TOGETHER during this case:		**The total time spent for these three % questions should equal 100%**

CGI: Considering your experience, how severe are the child's emotional, behavioral, and/or cognitive concerns at Discharge? (Circle one): *	Normal Slightly Severe Mildly Severe Moderately Severe Markedly Severe Very Severe Among the most severe symptoms that any child may experience	**CGI: Compared to the child's condition at intake, this child's condition is ____ (Circle one):** *	Very much improved Much improved Minimally improved No change Minimally worse Much worse Very much worse

Discharge Reason: *	❒	Successfully completed selected EBP Model requirements-no more treatment needed	❒	Referred for other EBP (outpatient) within agency	❒ Family moved out of area
	❒	Successfully completed selected EBP Model requirements-continue with other treatment	❒	Referred for other non-EBP (outpatient) within agency	❒ Referred to other agency (outpatient)
	❒	Family discontinued treatment	❒	Referred to higher level of care	❒ Assessment Only-no treatment needed
	Other (specify):				

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System Involvement						
Child/Family involved with DCF? *			❒	Yes	❒	No
If child / family is involved with DCF, please complete ALL of the following questions:						
DCF Case ID: (if available)			**DCF Person Link ID: (if available)**			
DCF Status: **DCF Regional Office:**	❒	Child Protective Services – In-Home	❒	Family with Service Needs – (FWSN) In-Home	❒	Not DCF – On Probation
	❒	Child Protective Services – Out of Home	❒	Family with Service Needs (FWSN) Out of Home	❒	Not DCF – Other Court Involved
	❒	Dual Commitment (JJ and Child Protective Services)	❒	Juvenile Justice (delinquency) commitment	❒	Termination of Parental Rights
	❒	Family Assessment Response	❒	Not DCF	❒	Voluntary Services Program
Youth involved with Juvenile Justice (JJ) System? *			❒	Yes	❒	No
If youth is involved with JJ, please complete ALL of the following questions:						
CSSD Client ID: (if available)			**CSSD Case ID: (if available)**			
CSSD Case Type:			❒	Delinquency	❒	Family with Service Needs (Status Offense)
CSSD Case Status:	❒	Administrative Supervision	❒	Juvenile probation	❒	Restore Probation
	❒	Extended Probation	❒	Non-Judicial FWSN Family Service Agreement	❒	Suspended Order
	❒	Interim Orders	❒	Non-Judicial Supervision (NJS)	❒	Waived PDS - Probation
	❒	Judicial FWSN Supervision	❒	Non-Judicial Supervision Agreement	❒	
Court District:						
Court Handling Decision:			❒	Judicial	❒	Non-Judicial
Treatment Information: School						
Since the start of EBP treatment…						
Child's school attendance: *	❒	Good (few or no days missed)	❒	No School Attendance: Child Too Young for School	❒	No School Attendance: Other
	❒	Fair (several days missed)	❒	No School Attendance: Child Suspended/Expelled from School		
	❒	Poor (many days missed)	❒	No School Attendance: Child Dropped Out of School		
Suspended or expelled: *			❒	Yes	❒	No
IEP: * Does the child have an Individual Education Plan (special education)?			❒	Yes	❒	No
Treatment Information: Legal						
Since the start of EBP treatment…						
Arrested: * Has the child been arrested since start of treatment?			❒	Yes	❒	No
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?			❒	Yes	❒	No
Treatment Information: Medical						

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Discharge Facesheet (MATCH-ADTC & TF-CBT)

Since the start of EBP treatment…				
Alcohol and/or drugs problems: *	❒	Yes	❒	No
Evaluated in ER/ED for psychiatric issues: *	❒	Yes	❒	No
Certified medically complex: *	❒	Yes	❒	No

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