

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 (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:	
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Child Identification Codes

Provider Client ID:		PSDCRS ID:	
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Session Information

Was there a visit this month? (Select one)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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Treatment Components

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

Collaboration

During this month, did you communicate with the child's:	<input type="checkbox"/>	DCF Worker	<input type="checkbox"/>	Probation officer	<input type="checkbox"/>	Physician
	<input type="checkbox"/>	School	<input type="checkbox"/>	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:	<input type="checkbox"/>	Very much improved since the initiation of treatment	<input type="checkbox"/>	Much Improved	<input type="checkbox"/>	Minimally improved
	<input type="checkbox"/>	No change from baseline (the initiation of treatment)	<input type="checkbox"/>	Minimally worse	<input type="checkbox"/>	Much Worse
	<input type="checkbox"/>	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?	<input type="checkbox"/>	None (0%)	<input type="checkbox"/>	Some (34-66%)	<input type="checkbox"/>	All (100%)
	<input type="checkbox"/>	A few (1-33%)	<input type="checkbox"/>	Most (67-99%)		
During how many sessions this month was homework assigned or reviewed?	<input type="checkbox"/>	None (0%)	<input type="checkbox"/>	Some (34-66%)	<input type="checkbox"/>	All (100%)
	<input type="checkbox"/>	A few (1-33%)	<input type="checkbox"/>	Most (67-99%)		
During how many sessions this month were COWS saved for the end of the session?	<input type="checkbox"/>	None (0%)	<input type="checkbox"/>	Some (34-66%)	<input type="checkbox"/>	All (100%)
	<input type="checkbox"/>	A few (1-33%)	<input type="checkbox"/>	Most (67-99%)		
During how many sessions this month did the child and/or caregiver practice/demonstrate skill(s) in session (behavior rehearsal)?	<input type="checkbox"/>	None (0%)	<input type="checkbox"/>	Some (34-66%)	<input type="checkbox"/>	All (100%)
	<input type="checkbox"/>	A few (1-33%)	<input type="checkbox"/>	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

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(Add ratings together) Total _____

January 2000 (Parent-1)

Response Scale for OHIO Problem Scale

0

Not at all

1

Once or
twice

2

Several
times

3

Often

4

Most of
the time

5

All of
the time

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

(Add ratings together) Total _____

Response Scale for OHIO Functioning Scale

0

Extreme
troubles

1

Quite a few
troubles

2

Some
troubles

3

OK

4

Doing
very well

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 _____

Response Scale for OHIO Problem Scale

0

Not at
all

1

Once or
twice

2

Several
times

3

Often

4

Most of
the time

5

All of
the time

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 _____

Response Scale for OHIO Functioning Scale

0

Extreme
troubles

1

Quite a few
troubles

2

Some
troubles

3

OK

4

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

Not at all

1

Once a week
or less/
a little

2

2 to 3 times a
week /
somewhat

3

4 to 5 times
a week / a
lot

4

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

Not at all

1

Once a week
or less/
a little

2

2 to 3 times a
week /
somewhat

3

4 to 5 times
a week / a
lot

4

6 or more times
a week/almost
always

YOUNG CHILD PTSD CHECKLIST (YCPC) (Caregiver: English)

For Child under 7 years old.

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/ Once in a while	2 to 4 times a week/ Half the time	5 or more times a week/ Almost always	Everyday

1.	Does your child have intrusive memories of the trauma? Does s/he bring it up on his/her own?	0	1	2	3	4
2.	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
3.	Is your child having more nightmares since the trauma(s) occurred?	0	1	2	3	4
4.	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
5.	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
6.	Does s/he get upset when exposed to reminders of the event(s)? 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.	0	1	2	3	4
7.	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? Think of the same type of examples as in #6.	0	1	2	3	4
8.	Does your child try to avoid 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
9.	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
10.	Does your child have difficulty remembering the whole incident? Has s/he blocked out the entire event?					
11.	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
12.	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

YCPC (Caregiver: English) continued

13.	Has your child lost hope for the future? For example, s/he believes will not have fun tomorrow, or will never be good at anything.					
14.	Since the trauma(s) has your child become more distant and withdrawn from family members, relatives, or friends?	0	1	2	3	4
15.	Has s/he had a hard time falling asleep or staying asleep since the trauma(s)?	0	1	2	3	4
16.	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
17.	Has your child had more trouble concentrating since the trauma(s)?	0	1	2	3	4
18.	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
19.	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
20.	Has your child become more physically aggressive since the trauma(s)? Like hitting, kicking, biting, or breaking things.	0	1	2	3	4
21.	Has s/he become more clingy to you since the trauma(s)?	0	1	2	3	4
22.	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
23.	Since the trauma(s), has your child lost previously acquired skills? For example, lost toilet training? Or, lost language skills? Or, lost motor skills working snaps, buttons, or zippers?	0	1	2	3	4
24.	Since the trauma(s), has your child developed any new fears about things that <u>don’t seem related</u> to the trauma(s)? What about going to the bathroom alone? Or, being afraid of the dark?	0	1	2	3	4
	FUNCTIONAL IMPAIRMENT Do the symptoms that you endorsed above get in the way of your child’s ability to function in the following areas?					
25.	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
26.	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
27.	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
28.	Do these (symptoms) “get in the way” with the teacher or the class more than average?	0	1	2	3	4
29.	Do (symptoms) make it harder for you to take him/her out in public than it would be with an average child? Is it harder to go out with your child to places like the grocery store? Or to a restaurant?	0	1	2	3	4
30.	Do you think that these behaviors cause your child to feel upset?	0	1	2	3	4

Young Child PTSD Checklist Caregiver Response Scale

0

Not at all

1

Once a
week/
Once in a
while

2

2 to 4 times
a week/
Half the
time

3

5 or more
times a week/
Almost
always

4

Everyday

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: _____

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): *	
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Child Identification Codes

Provider's Unique Client ID:		PSDCRS ID:	
Which EBP?	<input type="checkbox"/> MATCH-ADTC	<input type="checkbox"/> 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: *	<input type="checkbox"/> Successfully completed selected EBP Model requirements-no more treatment needed	<input type="checkbox"/> Referred for other EBP (outpatient) within agency	<input type="checkbox"/> Family moved out of area
	<input type="checkbox"/> Successfully completed selected EBP Model requirements-continue with other treatment	<input type="checkbox"/> Referred for other non-EBP (outpatient) within agency	<input type="checkbox"/> Referred to other agency (outpatient)
	<input type="checkbox"/> Family discontinued treatment	<input type="checkbox"/> Referred to higher level of care	<input type="checkbox"/> Assessment Only-no treatment needed
	Other (specify):		

Discharge Facesheet (MATCH-ADTC & TF-CBT)

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

Discharge Facesheet (MATCH-ADTC & TF-CBT)

Since the start of EBP treatment...			
Alcohol and/or drugs problems: *	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Evaluated in ER/ED for psychiatric issues: *	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Certified medically complex: *	<input type="checkbox"/>	Yes	<input type="checkbox"/>
			<input type="checkbox"/>
			No