

## Please use this tool as an interview guide

- (1) with children who have received individual crisis counseling on two or more occasions before this visit  
OR  
(2) with any child at any time if you suspect the child may be experiencing serious reactions to the disaster.

## ENCOUNTER INFORMATION

Provider Name	<div></div>	Provider #	<div></div>	Employee #	<div></div>
Date of Service (mm/dd/yyyy)	<div></div>	County Code of Service	<div></div>	Zip Code of Service	<div></div>
Visit Number	<input type="checkbox"/> 1st visit	<input type="checkbox"/> 2nd visit	<input type="checkbox"/> 3rd visit	<input type="checkbox"/> 4th visit	<input type="checkbox"/> 5th visit or more
Was parent or caregiver present during the visit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

READ: Occasionally, we find it helpful to ask children/adolescents or their parent/caregivers a few specific questions about how they were affected by the disaster and how they are feeling now. May I ask you these questions? My first questions are about various experiences you have had in the disaster.

## RISK CATEGORIES (check all that apply)

<input type="checkbox"/> family member missing or dead	<input type="checkbox"/> injured or physically harmed (self or household)	<input type="checkbox"/> evacuated quickly with no time to prepare
<input type="checkbox"/> friend missing or dead	<input type="checkbox"/> life was threatened (self or household)	<input type="checkbox"/> prolonged separation from family
<input type="checkbox"/> pet missing or dead	<input type="checkbox"/> witnessed death/injury (self or household)	<input type="checkbox"/> displaced from home 1 week or more
<input type="checkbox"/> home damaged or destroyed	<input type="checkbox"/> assisted with rescue/recovery (self or household)	<input type="checkbox"/> past substance use/mental health problem
<input type="checkbox"/> vehicle or major property loss	<input type="checkbox"/> disaster unemployed (self or household)	<input type="checkbox"/> pre-existing physical disability
<input type="checkbox"/> other financial loss	<input type="checkbox"/> had to change schools (for children or youth)	<input type="checkbox"/> past trauma

## DEMOGRAPHIC INFORMATION

<b>Age (select one)</b>	<b>Sex (select one)</b>	<b>Race (select one or more)</b>	<b>Ethnicity (select one)</b>
<input type="checkbox"/> preschool (0-5)	<input type="checkbox"/> male	<input type="checkbox"/> American Indian / Alaska Native	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> child (6-11)	<input type="checkbox"/> female	<input type="checkbox"/> Asian	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> adolescent (12-17)		<input type="checkbox"/> Black or African American	<b>Primary Language of Contact (select one)</b>
Grade Level in School <div></div>		<input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> English <input type="checkbox"/> Spanish
		<input type="checkbox"/> White	<input type="checkbox"/> other (specify)> <div></div>

PLEASE ALSO ANSWER QUESTIONS ON THE BACK

## Child/Youth Assessment & Referral Tool page 2: ASSESSMENT QUESTIONS

**INTRODUCTION:** I want to talk to you about your (your child's) feelings and thoughts about the disaster and how much they are causing problems *now*. Think about your thoughts, feelings, and behavior **DURING THE PAST MONTH** (*please remind child/parent of this for each question*). Use the frequency rating options **on the next page** and on the response card to help the child answer how often the problem has happened in the past month. For each question choose **ONE** of the following responses and check the appropriate box for that question.

0, not at all ☐

1, a little bit ☐

2, somewhat ☐

3, quite a bit ☐

4, very much ☐

1. Do you get upset, afraid or sad when something makes you think about the disaster?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

2. Do you have bad dreams or nightmares about what happened?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

3. Do you have upsetting thoughts or pictures that come into your mind about what happened?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

4. Do you try not to think about or talk about what happened?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

5. Do you stay away from places, people or things that make you remember the disaster?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

6. Do you have difficulty falling asleep or wake up often because of what happened?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

7. Do you feel jumpy or nervous?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

8. Do you find it harder to concentrate or pay attention to things than you usually do?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

9. Do you feel irritable or grouchy?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

10. Do you feel sad, down or depressed?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

11. Have you had more aches and pains, such as stomachaches or headaches?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

12. If in school: Do you find it harder to get your schoolwork done?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

13. Do you worry about something else bad happening to you/ your family/your friends?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

14. Are you having a harder time getting along with family or your friends?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

15. Are you finding it harder to do or enjoy activities that you used to enjoy?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

### ADDITIONAL QUESTIONS FOR PARENTS (Required for parents of children aged 0-7; recommended for parents of all children and adolescents)

16. Has your child been more clingy or worried about separation?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

17. Has your child been more quiet and withdrawn?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

18. Has your child talked repeatedly or asked questions about the disaster?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

19. Has your child's play been about the disaster?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

20. Have you noticed changes in your child's behavior or development (e.g., bedwetting, baby talk, fighting or risk-taking behavior, or decline in school performance)?

0 1 2 3 4  
☐ ☐ ☐ ☐ ☐

COUNT THE NUMBER OF ENTRIES IN THE 2 LAST COLUMNS ABOVE THAT HAVE A SCORE OF 3 OR 4. >>>>>>>>  
IF TOTAL NUMBER IS 4 OR MORE, DISCUSS THE POSSIBILITY OF A REFERRAL FOR SERVICES.

TOTAL  
NUMBER

**FOR CHILDREN OVER THE AGE OF 10 OR IF YOU ARE CONCERNED ABOUT A YOUNGER CHILD, YOU MAY ASK:** Have you had any thoughts or plans about either hurting or killing yourself?

☐ NO ☐ YES IF YES, refer for immediate psychiatric intervention. IF NO, continue to page 3.

PLEASE ENTER REFERRAL INFORMATION ON PAGE 3

## REFERRAL (select all that were communicated)

- ☐ other crisis counseling program services (e.g., group counseling, team leader, follow up)
- ☐ mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)
- ☐ substance abuse services (e.g., professional, behavioral, or medical treatment or self-help groups)

- ☐ school counseling
- ☐ community services (e.g., FEMA loans, housing, employment, social services)

Was the referral accepted by the child? ☐ Yes ☐ No

Was the referral accepted by the parent/caregiver? ☐ Yes ☐ No

## RESPONSE CARD (COUNSELOR COPY -- GIVE THE LARGER VERSION TO CHILD/PARENT BEFORE ASSESSMENT)

Think about your thoughts, feelings, and behavior **DURING THE PAST MONTH**. Use these frequency rating options to help answer how often the problem has happened in the past month. For each question choose **ONE** of the following responses.

0

S	M	T	W	Th	F	S

"Not at all" means  
never in the past month

1

S	M	T	W	Th	F	S
		X				
					X	

A "little bit" means about  
2 times per month

2

S	M	T	W	Th	F	S
		X			X	
		X				
			X			
	X			X		

"Somewhat" means about  
1-2 times each week during  
the past month

3

S	M	T	W	Th	F	S
	X		X		X	
X		X		X		
	X		X		X	
X		X				

"Quite a bit" means  
2-3 times a week during  
the past month

4

S	M	T	W	Th	F	S
X	X	X	X	X	X	X
X		X		X		X
	X		X	X	X	
X	X	X	X	X	X	X

"Very much" means  
Almost every day

## INSTRUCTIONS

PROVIDER NAME - The name of the program/agency.

PROVIDER # - The unique number your program/agency is providing services under.

EMPLOYEE # - YOUR employee number.

DATE OF SERVICE - The date of the encounter in the format MM/DD/YYYY, e.g., 01/01/2008.

COUNTY CODE OF SERVICE - The 3 digit FIPS code for the county where the service occurred.

ZIP CODE OF SERVICE - The zip code of the location where the service occurred.

LOCATION OF SERVICE - Where did you provide the service? **SELECT ONLY ONE.**

VISIT TYPE - Was this encounter with one person or with two or more related individuals (family). Please complete one form for each active participant. If the encounter was with two or more unrelated individuals, use the group counseling form.

VISIT NUMBER - Based on your conversation with the individual, is this the 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> or more visit for this person to your program? All visits did not have to be with you. **SELECT ONLY ONE.**

RISK CATEGORIES - These are factors that an individual may have experienced or may have present in their life that could increase their need for services. **MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.**

DEMOGRAPHIC INFORMATION - For each variable, **SELECT ONLY ONE.**

AGE - The age you perceived the person to be. **SELECT ONLY ONE.**

GRADE LEVEL - Please enter the number (e.g., 4 = 4th grade).

SEX - Was the person male or female? **SELECT ONLY ONE.**

RACE - Based on your observations and your conversation with the individual, what race would this person identify himself or herself as being? **SELECT ALL THAT APPLY.**

ETHNICITY - Based on your observations and your conversation with the individual, does this person self-identify as Hispanic/Latino? **SELECT ONLY ONE.**

PRIMARY LANGUAGE OF CONTACT - What language did you actually and primarily use to speak with this individual during the encounter? This may be different than the preferred language. If "OTHER" (not English or Spanish), fill in the other language. **SELECT ONLY ONE.**

REFERRALS - Based on your conversation with this individual, you may have referred the individual for other services. In the REFERRAL box, select all of the types of services you referred the person to.

Please submit the completed form to the designated person in your agency who will review the form.

**Thank you for taking the time to complete this form accurately and completely!**

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 20 minutes per encounter per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.