

Child Name: _____

Organization Name _____ Other: _____

MassHealth ID:

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Name (Last, First) _____

DOB (mm/dd/yyyy) _____

Gender

M ☐ F ☐ O ☐**RACE: Check up to three races that the client identifies as**

White	<input type="checkbox"/>	Black or African American	<input type="checkbox"/>	Native Hawaiian or other Pacific Islander	<input type="checkbox"/>
American Indian/Alaska Native (Wampanoag)	<input type="checkbox"/>	Hispanic/Latino/Black	<input type="checkbox"/>	Chooses not to Self-Identify	<input type="checkbox"/>
American Indian/Alaska Native (Other Tribal Nation)	<input type="checkbox"/>	Hispanic/Latino/White	<input type="checkbox"/>	Other	<input type="checkbox"/>
Asian	<input type="checkbox"/>	Hispanic/Latino/other	<input type="checkbox"/>		

ETHNICITY: Check up to three ethnicities that the client identifies as

American	<input type="checkbox"/>	French	<input type="checkbox"/>	Other – Asian	<input type="checkbox"/>
Afghan	<input type="checkbox"/>	French Canadian	<input type="checkbox"/>	Other – Caribbean	<input type="checkbox"/>
African American	<input type="checkbox"/>	German	<input type="checkbox"/>	Other – European	<input type="checkbox"/>
Albanian	<input type="checkbox"/>	Ghanian	<input type="checkbox"/>	Other – Latin America	<input type="checkbox"/>
Arab	<input type="checkbox"/>	Greek	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Argentinean	<input type="checkbox"/>	Guatemalan	<input type="checkbox"/>	Panamanian	<input type="checkbox"/>
Armenian	<input type="checkbox"/>	Haitian	<input type="checkbox"/>	Peruvian	<input type="checkbox"/>
Asian Indian	<input type="checkbox"/>	Hmong	<input type="checkbox"/>	Polish	<input type="checkbox"/>
Austrian	<input type="checkbox"/>	Honduran	<input type="checkbox"/>	Portuguese	<input type="checkbox"/>
Belgian	<input type="checkbox"/>	Hungarian	<input type="checkbox"/>	Puerto Rican	<input type="checkbox"/>
Bhutanese	<input type="checkbox"/>	Indonesian	<input type="checkbox"/>	Romanian	<input type="checkbox"/>
Brazilian	<input type="checkbox"/>	Iranian	<input type="checkbox"/>	Russian	<input type="checkbox"/>
British	<input type="checkbox"/>	Iraqi	<input type="checkbox"/>	Salvadoran	<input type="checkbox"/>
Bulgarian	<input type="checkbox"/>	Irish	<input type="checkbox"/>	Scandinavian	<input type="checkbox"/>
Cambodian	<input type="checkbox"/>	Israeli	<input type="checkbox"/>	Scottish	<input type="checkbox"/>
Canadian	<input type="checkbox"/>	Italian	<input type="checkbox"/>	Scottish Irish	<input type="checkbox"/>
Cape Verdean	<input type="checkbox"/>	Jamaican	<input type="checkbox"/>	Sierra Leonean	<input type="checkbox"/>
Chilean	<input type="checkbox"/>	Japanese	<input type="checkbox"/>	Somalian	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Kenyan	<input type="checkbox"/>	Sudanese	<input type="checkbox"/>
Columbian	<input type="checkbox"/>	Korean	<input type="checkbox"/>	Swedish	<input type="checkbox"/>
Costa Rican	<input type="checkbox"/>	Laotian	<input type="checkbox"/>	Swiss	<input type="checkbox"/>
Cuban	<input type="checkbox"/>	Latvian	<input type="checkbox"/>	Syrian	<input type="checkbox"/>
Czech	<input type="checkbox"/>	Lebanese	<input type="checkbox"/>	Thai	<input type="checkbox"/>
Danish	<input type="checkbox"/>	Liberian	<input type="checkbox"/>	Turkish	<input type="checkbox"/>
Dominican	<input type="checkbox"/>	Lithuanian	<input type="checkbox"/>	Ugandan	<input type="checkbox"/>
Dutch	<input type="checkbox"/>	Mexican	<input type="checkbox"/>	Ukrainian	<input type="checkbox"/>
Ecuadorian	<input type="checkbox"/>	Moldovan	<input type="checkbox"/>	Venezuelan	<input type="checkbox"/>
Egyptian	<input type="checkbox"/>	Moroccan	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>
English	<input type="checkbox"/>	Myanmar/Burmese	<input type="checkbox"/>	Welsh	<input type="checkbox"/>
Ethiopian	<input type="checkbox"/>	Nigerian	<input type="checkbox"/>	West Indian	<input type="checkbox"/>
Filipino	<input type="checkbox"/>	Norwegian	<input type="checkbox"/>	Chooses not to self-identify	<input type="checkbox"/>
Finnish	<input type="checkbox"/>	Other – African	<input type="checkbox"/>	Other	<input type="checkbox"/>

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PRIMARY LANGUAGE: Identify one from the list below

English	<input type="checkbox"/>	Greek	<input type="checkbox"/>	Serbian-Croatian	<input type="checkbox"/>
Albanian	<input type="checkbox"/>	Haitian Creole	<input type="checkbox"/>	Somali	<input type="checkbox"/>
American Sign Language	<input type="checkbox"/>	Hebrew	<input type="checkbox"/>	Spanish	<input type="checkbox"/>
Amharic	<input type="checkbox"/>	Hindi	<input type="checkbox"/>	Tagalog/Filipino	<input type="checkbox"/>
Arabic	<input type="checkbox"/>	Ibo/Igbo	<input type="checkbox"/>	Tamil	<input type="checkbox"/>
Armenian	<input type="checkbox"/>	Italian	<input type="checkbox"/>	Thai	<input type="checkbox"/>
Bosnian	<input type="checkbox"/>	Japanese	<input type="checkbox"/>	Tigrigna	<input type="checkbox"/>
Cantonese	<input type="checkbox"/>	Khmer/Cambodian	<input type="checkbox"/>	Turkish	<input type="checkbox"/>
Cape Verdean	<input type="checkbox"/>	Korean	<input type="checkbox"/>	Urdu	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Lao	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>
Farsi/Iranian/Persian	<input type="checkbox"/>	Mandarin	<input type="checkbox"/>	Yiddish	<input type="checkbox"/>
Finnish	<input type="checkbox"/>	Polish	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
French	<input type="checkbox"/>	Portuguese	<input type="checkbox"/>	Other	<input type="checkbox"/>
German	<input type="checkbox"/>	Russian	<input type="checkbox"/>		<input type="checkbox"/>

LANGUAGE at HOME: Identify one from the list below

English	<input type="checkbox"/>	Greek	<input type="checkbox"/>	Serbian-Croatian	<input type="checkbox"/>
Albanian	<input type="checkbox"/>	Haitian Creole	<input type="checkbox"/>	Somali	<input type="checkbox"/>
American Sign Language	<input type="checkbox"/>	Hebrew	<input type="checkbox"/>	Spanish	<input type="checkbox"/>
Amharic	<input type="checkbox"/>	Hindi	<input type="checkbox"/>	Tagalog/Filipino	<input type="checkbox"/>
Arabic	<input type="checkbox"/>	Ibo/Igbo	<input type="checkbox"/>	Tamil	<input type="checkbox"/>
Armenian	<input type="checkbox"/>	Italian	<input type="checkbox"/>	Thai	<input type="checkbox"/>
Bosnian	<input type="checkbox"/>	Japanese	<input type="checkbox"/>	Tigrigna	<input type="checkbox"/>
Cantonese	<input type="checkbox"/>	Khmer/Cambodian	<input type="checkbox"/>	Turkish	<input type="checkbox"/>
Cape Verdean	<input type="checkbox"/>	Korean	<input type="checkbox"/>	Urdu	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Lao	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>
Farsi/Iranian/Persian	<input type="checkbox"/>	Mandarin	<input type="checkbox"/>	Yiddish	<input type="checkbox"/>
Finnish	<input type="checkbox"/>	Polish	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
French	<input type="checkbox"/>	Portuguese	<input type="checkbox"/>	Other	<input type="checkbox"/>
German	<input type="checkbox"/>	Russian	<input type="checkbox"/>		<input type="checkbox"/>

REFERRED by: Check one from the list below

Inpatient Behavioral Health Unit	<input type="checkbox"/>	DYS	<input type="checkbox"/>	Clergy	<input type="checkbox"/>
Emergency Services provider	<input type="checkbox"/>	Court	<input type="checkbox"/>	Managed Care Company	<input type="checkbox"/>
CBAT	<input type="checkbox"/>	School	<input type="checkbox"/>	Other behavioral health provider	<input type="checkbox"/>
DMH	<input type="checkbox"/>	Primary Care Provider	<input type="checkbox"/>	Other	<input type="checkbox"/>
DDS	<input type="checkbox"/>	Family member	<input type="checkbox"/>		
DCF	<input type="checkbox"/>	Friend	<input type="checkbox"/>		

Child Name: _____

Organization Name _____ Other: _____

Identifying Children /Adolescents with Serious Emotional Disturbances¹

Serious Emotional Disturbance (SED) is a term that encompasses one or more mental illnesses or conditions. Whether a member has a SED can be determined by applying either Part I or Part II, below, or both. Identifying a child as having SED is one step in the determination of medical necessity for Intensive Care Coordination. In addition, MassHealth will be tracking SED determinations to guide service system improvements for children and families. Accurate identification of children with SED will help MassHealth improve services for this population in the future.

A child may have a SED under Part I or Part II or both². All criteria in part 1 and part 2 must be considered and ruled in or out.

Part I:

Please answer the following questions according to your current knowledge of the child or adolescent:

1. Does the child currently have, or at any time in the last 12 months has had, a diagnosable DSM-5 or ICD-10 disorder(s)? Developmental disorders, substance abuse disorders or V-codes are not included unless they co-occur with another DSM-5 or ICD-10 diagnosis.

☐ Yes ☐ No
2. If yes to question 1, please indicate whether those diagnoses resulted in functional impairment, which substantially interferes with, or limits, the child's role or functioning in any of the following areas. (Functional impairment is defined as difficulties, which substantially interfere with or limit his or her ability to achieve or maintain one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment)

☐ Family ☐ School ☐ Community activities ☐ No functional impairment as defined
3. If yes to question 1, and you checked "no functional impairment as defined" in question 2: Would the child have met one or more of the functional impairment criteria in question 2 without the benefit of treatment? (Children who would have met functional impairment criteria during the year without the benefit of treatment or other support services are included.)

☐ Yes ☐ No

Part II:

4. Please indicate if the child has exhibited any of the following over a long period of time and to a marked degree that adversely affects the child's educational performance:

(a) An inability to learn that cannot be explained due to intellectual, sensory, or health factors.
☐ Yes ☐ No

¹ SED = "Serious emotional disturbance"

² The determination that a child meets these clinical criteria is not an evaluation under federal and state laws addressing special education.

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If yes to (a), is this solely the result of autism, mental retardation, specific learning disability, hearing impairment, visual impairment, deaf-blindness, speech or language impairment, orthopedic impairment, traumatic brain injury, other health impairment, or multiple disabilities not including a serious emotional disturbance? ☐ Yes ☐ No

- (b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
☐ Yes ☐ No

If yes to (b), is this solely the result of autism, mental retardation, specific learning disability, hearing impairment, visual impairment, deaf-blindness, speech or language impairment, orthopedic impairment, traumatic brain injury, other health impairment, or multiple disabilities not including a serious emotional disturbance? ☐ Yes ☐ No

- (c) Inappropriate types of behavior or feelings under normal circumstances. ☐ Yes ☐ No

If yes to (c), is this solely the result of autism, mental retardation, specific learning disability, hearing impairment, visual impairment, deaf-blindness, speech or language impairment, orthopedic impairment, traumatic brain injury, other health impairment, or multiple disabilities not including a serious emotional disturbance? ☐ Yes ☐ No

- (d) A general pervasive mood of unhappiness or depression. ☐ Yes ☐ No

If yes to (d), is this solely the result of autism, mental retardation, specific learning disability, hearing impairment, visual impairment, deaf-blindness, speech or language impairment, orthopedic impairment, traumatic brain injury, other health impairment, or multiple disabilities not including a serious emotional disturbance? ☐ Yes ☐ No

- (e) A tendency to develop physical symptoms or fears associated with personal or school problems.
☐ Yes ☐ No

If yes to (e), is this solely the result of autism, mental retardation, specific learning disability, hearing impairment, visual impairment, deaf-blindness, speech or language impairment, orthopedic impairment, traumatic brain injury, other health impairment, or multiple disabilities not including a serious emotional disturbance? ☐ Yes ☐ No

5. Please check this box if you identified a functional impairment in question 2 or answered “yes” to question 3 → ☐ **The child /adolescent has SED under Part I.**

6. Please check this box if you checked one or more “no” boxes in the right hand column of question 4 → ☐ **The child /adolescent has SED under Part II.**

Clinician name, degree (print): _____

Clinician signature: _____

Date: _____

Child Name: _____

Organization Name _____ Other: _____

Massachusetts Child and Adolescent Needs and Strengths (CANS)

Needs Scale Key = Please rate the highest level of need in the past 30 days (unless otherwise specified).

0 = No evidence or no reason to believe that the rated item requires any action.

1 = A need for watchful waiting, monitoring or possibly preventive action.

2 = A need for action. Some strategy is needed to address the problem/need.

3 = A need for immediate or intensive action. This level indicates an immediate safety concern or a priority for intervention.

LIFE DOMAIN FUNCTIONING

	0	1	2	3		0	1	2	3
1. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Comm., Comp & Express.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Preschool/Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Recreation/Play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Feeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Parent/Child Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Relationship Permanence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Comments on LIFE DOMAIN FUNCTIONING

CHILD BEHAVIORAL/EMOTIONAL NEEDS

	0	1	2	3		0	1	2	3
18. Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Hyperactivity/Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Regulatory: Body/Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Adjustment to Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Atypical Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

27. Comments on CHILD BEHAVIORAL/EMOTIONAL NEEDS

Child Name: _____

Organization Name _____ Other: _____

CHILD RISK FACTORS & BEHAVIORS

	0	1	2	3		0	1	2	3
28. Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Sanction Seeking Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Frustration Toler./Tantrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Comments on CHILD RISK FACTORS & BEHAVIORS

Strengths Scale Key = Please rate the highest level of strength in the past 30 days (unless otherwise specified).

0 = Significant strength or strength can be used as a centerpiece for strength-based treatment plan.

1 = Strength exists or can be useful in treatment plan.

2 = Potential strength or requires significant strength building in order to be used in treatment plan.

3 = No strength identified at this time or efforts *may be* required to identify strengths in order to be used in treatment plan.**CHILD STRENGTHS**

	0	1	2	3		0	1	2	3
33. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Curiosity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Interpersonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Playfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Adaptability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Creativity/Imagination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Persistence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. Comments on CHILD STRENGTHS

Needs Scale Key = Please rate the highest level of need in the past 30 days (unless otherwise specified).

0 = No evidence or no reason to believe that the rated item requires any action.

1 = A need for watchful waiting, monitoring or possibly prevention action.

2 = A need for action. Some strategy is needed to address the problem/need.

3 = A need for immediate or intensive action. This level indicates an immediate safety concern or a priority for intervention.

N/A = There is no permanent caregiver known at this time.

Child Name: _____

Organization Name _____ Other: _____

CULTURAL CONSIDERATIONS

	0	1	2	3		0	1	2	3
42. Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. Cultural Differences within a Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Discrimination/Bias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. Youth/Family Relationship to System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Cultural Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Agreement about Strengths and Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. Comments on CULTURAL CONSIDERATIONS

CAREGIVER RESOURCES AND NEEDS

Caregiver Name _____

Caregiver Relationship to child: _____

	0	1	2	3	N/A		0	1	2	3	N/A
49. Medical/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55. Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58. Natural Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Family Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59. Financial Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Housing Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

60. Comments on CAREGIVER RESOURCES AND NEEDS

Child Name: _____**Organization Name** _____ **Other:** _____**Diagnostic Factors:**

61. Medical Conditions:

62. Psychosocial and Environmental Stressors:	No Dx	
Problems with Primary Support Group	<input type="checkbox"/>	<input type="checkbox"/>
Problems Related to Social Environment	<input type="checkbox"/>	<input type="checkbox"/>
Educational Problems	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Problems	<input type="checkbox"/>	<input type="checkbox"/>
Housing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Problems with Access to Health Services	<input type="checkbox"/>	<input type="checkbox"/>
Problems Related to Interactions with	<input type="checkbox"/>	<input type="checkbox"/>
Other Psychosocial and Environmental Stressors	<input type="checkbox"/>	<input type="checkbox"/>

63. CGAS (0-100):

For additional information regarding the CGAS: Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). Archives of General Psychiatry, 40(11), 1228-1231.

	0	1	2	3
64. Diagnostic Certainty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. Prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

65. Comments on DIAGNOSIS

SUMMARY:

66.

Child Name: _____**Organization Name** _____ **Other:** _____**CLINICIAN**

Clinician Name/Degree:

Clinician Signature:

Date:

<input type="checkbox"/>	Complete
<input type="checkbox"/>	Incomplete but Final

Reason:

☐ Client did not return☐ Other: