Dakota Children's
ADVOCACY CENTER

Telehealth Outreach Program

Screen

Client Name: _____ DOB: _____

Clinical Questions

1. Does the child/adolescent have any vision or hearing problems? If yes, please explain:

   _____

2. Does the child/adolescent have attention/concentration problems? If yes, please explain:

   _____

3. Does the child/adolescent have a past or current diagnosis of ADHD? If yes, are they currently being treated by a provider? If yes, what is the status of treatment?

   _____

4. Does the child/adolescent have any harm to self-safety concerns (past or current self-harm, past or current suicidal ideations)? If yes, please explain:

   _____

5. Does the child/adolescent have any harm to others safety concerns (past or current aggression towards others)? If yes, what's their relationship to the child (i.e. parents, teachers, siblings, etc.)? If yes, please explain:

   _____

6. Does the child/adolescent have any harm to property concerns (past or current aggression towards objects i.e. damages property when upset)? If yes, please explain:

   _____

7. Does the child/adolescent have any past or current legal issues involving technology (i.e. pornography)? If yes, please explain:

   _____

8. Does the child/adolescent have any past or current risky behaviors with technology (meeting strangers online)? If yes, please explain:

   _____

9. Does the child/adolescent have any other past or presenting problems that may interfere with their ability to fully participate in TF-CBT via Telehealth? If yes, please explain:

   _____

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Logistics Questions

1. Are you, or a designated adult, able and willing to be present during the entire duration of the telehealth session? ☐ YES ☐ NO

2. Are you able and willing to provide designated adults as emergency contacts for the safety plan? ☐ YES ☐ NO

3. Are you, or a designated adult, able and willing to follow a safety plan if an emergency were to take place during the telehealth session? ☐ YES ☐ NO

4. Are you able and willing to participate in sessions, either at the same time as the child's session or another agreed upon time, as needed with your child/adolescent? ☐ YES ☐ NO

5. Is there a quiet location in which the child/adolescent can have privacy during telehealth sessions? (privacy means = a room with a door that shuts) ☐ YES ☐ NO

6. Do you have a way to reduce the likelihood that confidentially will be violated during the session, such as a sound machine or noise app? ☐ YES ☐ NO

7. Are you able and willing to respect the privacy of the child/adolescent during the telehealth sessions? (not interrupting, not listening by the door, not allowing others in the home to interrupt sessions, not asking your child/adolescent after session to explain the details of what was discussed) ☐ YES ☐ NO

8. Do you have any questions or concerns about your child/adolescent participating telehealth that have not been discussed in the above questions? If yes, please explain: ☐ YES ☐ NO