**Social Skills Group Parent Referral Questions**

Child’s Name:

DOB:

Date of Intake:

Email Address of Parent**:**

Has the child had a recent evaluation though a Children’s Hospital Colorado clinic?

Yes Date:

No

Has the child had a recent evaluation or IEP though an outside provider?

Yes Date:

No

**\*\*If yes, we ask that you include a copy of the child’s outside evaluation report for review.**

1. Does the child have a diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What therapies is the child currently receiving (list names of therapists)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What is the child’s language level?

Not verbal

Uses only single words

Combines 2-3 words into phrases

Uses long sentences

Comments:

4. How does your child respond to unfamiliar people and settings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Does the child respond to questions?

Yes

Sometimes

With Help or Two Choices

No

Comments:

6. How long can your child sit through structured activities?

Less than 5 minutes

5-10 minutes

More than 10 minutes

Comments:

7. Does the child have any difficult behaviors (such as hitting/pushing, tantrums, yelling, refusal, etc.)? If yes, what are the behaviors and is your child easily redirected?

8. Do you have safety concerns when your child is in the community? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What are your main goals for your child in a social skills group?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. What is your preferred location for a group (indicate first and second choice):

Aurora Broomfield Parker Littleton

Comments:

11. What days and times of day is your child available to attend a group? (or not available, whichever you prefer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by (parent, treating therapist?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions please call: 720-777-6611