CHILD COUNSELING/THERAPY SUMMARY

Child's name: ___________________ DOB: _________________

Guardian's Name:_________________ Guardian's Phone #:__________________

Name of provider:	
Agency/Address:	
Phone #:	
Fax #:	
E-mail address:	

I hereby give my consent for____to release information to Big Brothers Big Sisters of Central New Mexico about my child. This authorization shall be effective until my termination from the Big Brothers Big Sisters program.

Guardian's signature: ____________________________ Date: _______________________________

Dear Counselor/Therapist/Psychologist/Psychiatrist:

_________________________________has applied to be a little with our organization. As a matter of policy and part of our screening process, we thoroughly evaluate each applicant. This includes obtaining information regarding psychological, psychiatric, medical care and/or any other information, which may have a bearing on the applicant's ability to participate in the Big Brother or Big Sister program. All information is kept confidential and is for agency use only.

The Big Brothers Big Sisters program requires a one-year commitment either weekly or twice per month (depending on program) spending time one-on-one with a mentor in either a community-based or site-based setting.

At the top of this form, you will find a signed Release of Information from the child's guardian. If you would take a moment to answer the following questions, it would be greatly appreciated. You can return it to me by fax at 1.505.213.2341. If you wish to discuss the questions with me personally, I can be reached at the contact information below.

Thank you for your time. I look forward to receiving your response soon.

Sincerely,

Gabrielle Keigher
Enrollment Manager
505-300-8089
gabrielle.keigher@bbbs-cnm.org

Big Brothers Big Sisters.

CHILD COUNSELING/THERAPY SUMMARY

1. Dates/length of involvement and frequency of visits:

2. When was the last time the child was seen by you?

3. For what initial concerns or problems did the family seek your services?

4. Describe the child's personality and interests:

5. Child's current diagnosis:

6. Please list all medications/dose the applicant is taking (if so, for how long)?

7. How long has this child been on these medications? Has progress been made?

8. Are you aware of any potential triggers (emotional, psychological, and environmental)?

9. Would there be any negative repercussions if the dosage was altered or the individual stopped taking these medications?

10. What are the youth's strengths and talents?

11. Please share any information regarding the child's home, family, or time out of school that may be helpful in understanding how to best serve this child:

12. Do you have any reservations about the child being able to maintain a positive relationship with an adult outside of their family for a 1- year commitment?

13. The role of a mentor is to be a friend to the child, they do not receive any mental health training prior to being matched, can you name any significant behaviors or traits of this child that need to be taken in to consideration?

14. How do you feel this youth would benefit from a mentoring relationship? In what specific ways can a mentor help this youth?

15. What would be helpful for a mentor to know in building a relationship with the youth? What advice do you have for a mentor?

16. What type of volunteer (*personality, skill set, life experience, etc.)* do you feel would best meet the needs of the youth in a mentoring relationship?

17. What else do you think is important to consider when thinking about the best match or mentor experience for the youth?

18. Please explain why you would or would not recommend this child to be matched with a mentor:

19. Please add any additional information you would like to share:

Signature of Provider: ___________________________________Date:______________________________