## APPENDIX A: SAMPLES OF CLINICAL FORMS

**On the following pages you will find examples of clinical forms to adapt for your use.**



**You can also access these form samples to adapt to your own use in editable Word documents and the same PDF version at our website:**

- **Full-text LINK to Word version of samples of clinical forms**
  Note that when you click on this link, the editable Word document (.docx) will download to your computer or device. Please check the regular location on your computer or device for downloaded documents.
- **Full-text LINK to PDF version of samples of clinical forms**
  This is a downloadable PDF of Appendix A.

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

**SUMMARY OF CONTACT WITH CLIENT**

| Client ID Number | Date | Summary of Contact |
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_____ _____

Therapist Signature Therapist Name Date

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

## CLIENT INFORMATION (SAMPLE)

Please fill out the following form as completely as possible.

Name:_____ Today's Date:_____

Date of Birth: _____ Age:_____ Gender: □Female □Male

Home Address: _____ Apt/Unit:_____

City: _____ State:_____ Zip:_____

**Contact Telephone Numbers**

Please complete relevant information and indicate the number at which you wish to be contacted first.

Home: ( ) _____ Can we leave a message at this number? □ Yes □ No
Work: ( ) _____ Can we leave a message at this number? □ Yes □ No
Cell: ( ) _____ Can we leave a message at this number? □ Yes □ No

**Marital Status**

□ Single □ Divorced ( ___ years) □ Living as Married ( ___ years)
□ Married (___ years) □ Separated ( ___ years) □ Widowed ( ___ years)

Spouse's/Partner's Name: _____

If we are unable to reach you, is it OK to contact your spouse/partner? □Yes □No
If yes, spouse/partner's phone number: ( ) _____

Names and ages of children (if any):

_____ _____ _____ ____
_____ _____ _____ ____
_____ _____ _____ ____

Are there any other individuals who live in your home? □ Yes □ No
If yes, please indicate name and relationship: _____

**Emergency Contact Information**

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and the rules of my profession to contact someone close to you (relative, spouse, close friend).

Name: _____

Address: _____

Phone: ( ) _____ Relationship to you: _____

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

**Referent**

By whom were you referred?_____

**Other Professionals Involved in Your Treatment**

Medical Provider/Clinic Name: _____

Address:_____ Phone:_____

May I have your permission to contact this person for continuity of care: □Yes □No

Psychiatric Provider/Clinic Name:_____

Address:_____ Phone:_____

May I have your permission to contact this person for continuity of care? □Yes □No

**Type of trauma experienced:**

_____

_____

**Date, or length of time since it occurred** _____

**Education:**

□ Primary school
□ High School
□ Trade School
□ College graduate
□ Graduate program
□ Professional Degree

**Employment Status:**

Are you employed? □ Yes □ No Are you using EAP? □Yes □No

Employer Name: _____

Position: _____

**Thank you!**

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

## SAMPLE CONSENT APPROPRIATE FOR ADULTS

**NOTE: You can either modify the Consent Template for Adults or use the below sample letter to obtain written consent. The information in this letter must include all of the following elements found in the Consent Form for Adults, which contains detailed information about each element:**

**TITLE OF PROJECT**
**RESEARCHER'S NAME(S) AND CONTACT INFORMATION**
**PURPOSE OF STUDY**
**DURATION AND LOCATION OF STUDY**
**PROCEDURES**
**POTENTIAL RISKS AND DISCOMFORTS**
**BENEFITS**
**CONFIDENTIALITY/ANONYMITY**
**COMPENSATION FOR PARTICIPATION**
**RIGHT TO REFUSE OR WITHDRAW**
**OFFER TO ANSWER QUESTIONS**

## CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in a research study entitled (fill in title of project) conducted by (researcher's name), and (affiliation)

**WHAT THE STUDY IS ABOUT:**

The purpose of this research study is to ... (Describe the purpose or objectives of the research clearly and concisely in language appropriate to the subject population).

**WHAT WE WILL ASK YOU TO DO:**

During this study, the following will happen.... (As clearly as possible, describe in lay language, step by step, what you will ask the participant to do or what will be done to the participant).

**DURATION AND LOCATION OF THE STUDY:**

Your participation in this study will involve (give expected duration, number of sessions, and time frame of the sessions, e.g., "one session that lasts one hour"; "three 30-minutes sessions once a week for three weeks" ). The study will take place (give location of study).

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

**POTENTIAL RISKS AND DISCOMFORTS:**

The research procedures described above may involve the following risks and/or discomforts: (Outline any foreseeable risks -- physical, psychological, social, economic, legal -- that might be greater than those encountered in everyday life and note any expected discomforts participants may encounter, explaining their likelihood and significance.). If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

**MEDICAL CONCERNS:**

If you have any medical issues that might impair your ability to take part fully in treatment, you should contact your medical provider to get clearance for participating in EMDR. If you have any legal issues that might be impacted by your treatment, you should contact your attorney to discuss this form of treatment and get clearance for participating in this study.

**BENEFITS:**

The possible benefits to you of participating in this study are (describe)_____.

**PRIVACY/CONFIDENTIALITY:**

*(NOTE: Anonymity means that no identifying information such as name or student ID number is collected, so the privacy of participants is assured. Confidentiality means that the researcher (or perhaps the instructor) will have a record of who participated but the data will be kept private.)*

Because you will not be providing any information that can uniquely identify you (such as your name), the data you provide will be anonymous.

**OR**

Any data you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will ... [explain how you will keep their names and data secure and who will have access to the data, e.g., your research assistants, your advisor, your teacher, your classmates.)

*(NOTE: If there is a master list that includes the participant's name and a code linking the name to the data, this must be made explicit to participants and the master list must be kept secure and separately from the collected data. Explain when the consent forms and any other identifiable data will be destroyed. Note: The IRB requires PIs to keep consent forms for 3 years. You do not ever have to destroy raw data but at some reasonable point, you should destroy anyone's ability to link the participants' data to identifying information.)*

**COMPENSATION/PAYMENT FOR PARTICIPATION:**

There is no payment or other form of compensation for your participation in this study.

**OR**

You will receive _____for your participation in this study. If you choose to withdraw before completing the study, you will receive_____.

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

*(NOTE: If participants are to be compensated or paid, specify compensation [e.g. research participant pool credit; extra credit for course] or dollar amount and address the matter of proration if participant withdraws or if the study is terminated by the researcher. If there is no compensation, specify that that is the case by saying that there will be no financial compensation for participation in the study.)*

**VOLUNTARY NATURE OF THE STUDY:**

Your participation is voluntary and you may refuse to participate without penalty or loss of benefits. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty or loss of benefits [or describe how it may be prorated for early withdrawal]. In addition, the researcher has the right to withdraw you from participation in the study at any time.

*(NOTE: PI may omit the phrase "loss of benefits" if it does not apply to the research. If participants are students, patients, or employees, explicitly note that nonparticipation or withdrawal from the study will not affect their grade, employment status, or treatment, as appropriate.)*

**OFFER TO ANSWER QUESTIONS:**

Please ask any questions you have now. If you have questions later, you should contact the principal investigator: (name of PI) at (phone number) or (email address).

**I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.**

_____

*PARTICIPANT'S SIGNATURE* *DATE*

ADDITIONAL ITEMS TO NOTE:

**EXPERIMENTAL TREATMENTS:** When appropriate, be sure to explicitly identify any procedures that are experimental and disclose appropriate alternative procedures or courses of treatment, if any, which might be advantageous to the subject;

**GREATER THAN MINIMAL RISK STUDIES:** For research involving more than minimal risk, include an explanation as to whether any compensation or medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained. In addition, explicitly note who to contact in the event of a research-related injury to the subject.

**VIDEO AND AUDIORECORDINGS:** For studies in which audio or video recording of participants are to be made, the consent form should include information as to why the recordings are needed for the research, where and how they will be stored and identified, and what will be done with them upon completion of the research (e.g., archived after transcription, kept indefinitely, destroyed after X years).

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

**EXAMPLE: CONSENT FOR AN OLDER CHILD**

(Date)

Dear _____:

**Identify yourself, your position, the request and a description of the study**

*My name is _____ and I am (state your position or affiliation). I am asking you to participate in a project that examines the effectiveness of an intervention for children/adolescents who have suffered a traumatic event).

**Outline the procedure to screen for eligibility, the requirements of the study, rights to discontinue, risks, and confidentiality**

*I am asking you to fill out 3 short questionnaires that will take less than 30 minutes. After filling out the forms, if you are eligible to participate, you will be invited to participate in a study and receive 4-6 sessions of EMDR. After you receive the therapy, you will be asked to fill out 2 questionnaires again and you will then be asked again 3 and 6 months later to fill out the same 2 forms again. Your parents or legal guardians have already given permission for you to participate in this study, but you do not have to participate if you do not want to. You may quit this study at any time by simply telling me that you do not want to continue. You can skip any questions or tasks that you do not want to complete. Your participation in this study will not affect your grades in any way. There are no known risks involved in this study and you will receive nothing for your participation. To protect your confidentiality, your responses will not be shared with anyone unless required by law. Your teacher will not know if you chose to participate in this project and neither your parents or teacher will know any of answers to your questions which will be kept by me.

**Provide your contact information**

If you have any question about this study, please contact me at _____.

Sincerely yours,

*Signature*

_____

**Professional signature line**

***Example of information to be included**

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

**Agreement**

I agree to participate in this research project and I have received a copy of this form.

_____

*Student's Name (Please Print)* *Date*

_____

*Student's Signature*

I have explained to the above named individual the nature and purpose, benefits and possible risks associated with participation in this research. I have answered all questions that have been raised and I have provided the participant with a copy of this form.

_____

*Researcher* *Date*

*Appendix A: Samples of Clinical Forms - These forms should be adapted to the situation and particular needs of the project*

**SAMPLE OF PARENT PERMISSION FOR CHILD**

(Date)

Dear Parents,

My name is (research assistant's name) and I am a (give name, position, and role within the research project). We are writing this letter to explain why we would like for you and your child to participate in our research project *Group Intervention Study for Children and Adolescents and their Parents Exposed to Trauma.* We are studying the effectiveness of an intervention with children/adolescents and their parents called the Integrative Trauma Group Protocol-Eye Movement Desensitization and Reprocessing (IGTP-EMDR) on disturbing symptoms that can result from a traumatic event. There are a variety of EMDR protocols with the IGTP protocol that has been developed specifically for use in groups. When a disturbing event occurs, it can get locked in the brain with the original picture, sounds, thoughts, feelings and body sensations. This protocol seems to stimulate the information and allows the brain to reprocess the experience to a healthy, adaptive resolution. That may be what is happening in REM or dream sleep.

If your child is eligible to participate and you and s/he agree, s/he will be in a group with 3 other children and 2 therapists for a one-day workshop that will last no longer than 6 hours. The IGTP-EMDR protocol consists of the following: your child will be asked to imagine a place that feels calm and safe and to draw a picture of that place and then to gently pat their upper chest with their opposite hand for a minute. The IGTP-EMDR is also called the "butterfly hug". Your child can share their calm place with the group if s/he wishes but does not have to. Then your child will be asked to draw a picture of the most disturbing part about what happened to them. Your child will not be asked to share what is disturbing with anyone but to only draw the picture. Your child will repeat the butterfly hug while looking at their drawing. This will be repeated 3-4 more times as needed until it is less disturbing. The group will end with a positive picture about how your child would like to feel in the future. We would like to see if this intervention helps to decrease disturbing symptoms in the present and strengthens your child's well-being in the future. Parents will also be offered a one day workshop explaining trauma symptoms and will also participate in the same protocol as their children as described above. Parents do not have to participate in this study to attend the workshop. If you do not want your child to participate, your child can still get help through a referral to an individual therapist.

With your permission if your child participates, I will ask your child to complete 2 short questionnaires that would take less than 20 minutes and if your child is eligible to participate, then s/he will be asked to fill out 2 more forms again taking less than 20 minutes to fill out prior to the group. Your child, if eligible, will be invited to attend a one day workshop with 3 other children led by 2 licensed mental health providers. Your child's participation in this study is completely voluntary and will not affect his or her grades in any way. Your child may quit this study at any time by simply saying "Stop" or "I do not wish to participate." You will also be asked to fill out 2 forms about your child that will take about 15 minutes. If your child is eligible to participate in this project, than you will be contacted and asked to fill

out 1 questionnaire again after your child the group ends and then again at 3 and 6 months later. Your child will be asked to fill out 2 questionnaires again at the end of EMDR and then again 3 and 6 months later. If you the parent wish to participate in the study, you will be asked to fill out 2 forms before and after the workshop and then again 3 and 6 months later. The forms that you and your child will be asked to fill out measure symptoms of trauma and it is hoped that this workshop will help to decrease these symptoms.

The study will be conducted at the therapist's office. There are no known risks involved in this study and neither you nor your child will receive any compensation for his or her participation. To protect you and your child's confidentiality, your child's name nor your name will not appear on any record sheets. The information obtained will not be shared with anyone, unless required by law. The records will be maintained by me. If you have any questions, please contact **(Give name and contact information for the person who is in charge of the study)**. If you or your child does not want to participate, your child will be referred to a therapist for individual psychotherapy.

It is hoped that disturbing symptoms will be decreased and there is some preliminary research that shows that the IGTP-EMDR protocol does decrease disturbing symptoms caused by an adverse experience. If there is any discomfort experienced by your child in the group, s/he will be receive stabilization if in the clinical judgment of the therapists this is warranted and the referred for individual therapy. This letter will serve as a consent form for your child's and your participation and will be kept **(state where the records will be maintained)**. If you have any questions about you or your child's rights as a participant, please contact (**Give name and contact information of person who can give further information about the study)**.

Sincerely yours,

*Signature*

_____

**Professional signature line**

**PLEASE READ**

# EMDR EARLY INTERVENTION RESEARCHER'S TOOLKIT

## *Version 02.2015 Release Notes*

**In this updated version [02.2015] of the EMDR Research Foundation's EMDR Early Intervention Researcher's Toolkit, there are corrections to faulty hyperlinks in the earlier version. Always use the most recent version available.**

**Check our website at www.emdrresearchfoundation.org/toolkit/ to download the latest version.**

**For better functionality of hyperlinks please FIRST *SAVE* this document to your computer. *Once saved, open the document on your computer* (not browser) using Adobe Reader or Adobe Acrobat.**

**Go to http://get.adobe.com/reader/ for an up to date, free version of Adobe Reader for your operating system and browser.**


**EMDR EARLY INTERVENTION RESEARCHER'S TOOLKIT *version 02.2015***



**Please complete the online EEI RESEARCHER'S TOOLKIT USER REGISTRATION FORM to receive future updates, information, and opportunities. For the latest Toolkit version, go to www.emdrresearchfoundation.org/toolkit**