

 Clinical Supports to Foster Families

 Referral Form

Date of Referral:Click here to enter a date. Referred by:Click here to enter name.

 Program has been explained to client yes[ ]  no[ ]  Consent Form attached: yes[ ]  no[ ]

IDENTIFIED CHILD/REN

|  |  |  |
| --- | --- | --- |
| **1. Name:** Last Name First NameClick here to enter text. |  **D.O.B** . Year/Month/Day Click here to enter text. | **Gender**: Male [ ]  Female [ ]   |
| **Address:** include postal codeClick here to enter text. | **Phone:** Click here to enter text. |
| **Physician:**Click here to enter text. | **Health Card #:**Click here to enter text. |
| **School:** Click here to enter text. | **Grade:**Click here to enter text. | **First Nations:** Yes [ ] No [ ]  |
| **Allergies:**Click here to enter text. | **Medication:**Click here to enter text. |
| **2. Name:** Last Name First NameClick here to enter text. |  **D.O.B** . Year/Month/DayClick here to enter text. | **Gender**: Male [ ]  Female [ ]   |
| **Address:** include postal codeClick here to enter text. | **Phone:** Click here to enter text. |
| **Physician:** Click here to enter text. | **Health Card #:**Click here to enter text. |
| **School:** Click here to enter text. | **Grade:** Click here to enter text. | **First Nations:** Yes [ ] No [ ]  |
| **Allergies:** Click here to enter text. | **Medication:** Click here to enter text. |

Child/ren is/are currently residing with: [ ] Mother [ ] Father [ ] Grandparents

 [ ] Foster Care [ ] Group Home [ ] Other

Marital Status of Parents: [ ] Single [ ] Married [ ] Common-Law [ ] Separated

 [ ] Divorced [ ] Widowed

MOTHER:

|  |  |
| --- | --- |
| **Name:** Last Name First NameClick here to enter text. | **D.O.B.** Year/Month/DayClick here to enter text. |
| **Place of Employment:** Click here to enter text. | **Home phone:**Click here to enter text. |
| **Address (if different than child)** Click here to enter text. | **Work phone:**Click here to enter text. |
| **Cell phone:**Click here to enter text. |

FATHER:

|  |  |
| --- | --- |
| **Name:** Last Name First NameClick here to enter text. | **D.O.B.** Year/Month/DayClick here to enter text. |
| **Place of Employment:** Click here to enter text. | **Home phone:**Click here to enter text. |
| **Address (if different than child)**Click here to enter text. | **Work phone:**Click here to enter text. |
| **Cell phone:**Click here to enter text. |

STEP-PARENTS: (Include only if currently living with either the mother or the father)

|  |  |  |
| --- | --- | --- |
| **Step Mother’s Name**Click here to enter text. | **D.O.B.**Click here to enter text. | **Phone:**Click here to enter text.**Cell:**Click here to enter text. |
| **Step Father’s Name:**Click here to enter text. | **D.O.B.**Click here to enter text. | **Phone:**Click here to enter text.**Cell:**Click here to enter text. |

FOSTER PARENT(S):

|  |  |
| --- | --- |
| **Name(s):**Click here to enter text. | **Phone:**Click here to enter text.**Cell:**Click here to enter text. |
| **Address:**Click here to enter text. |

SIBLINGS – currently living with child

|  |  |  |  |
| --- | --- | --- | --- |
| **Sib #** | **Name** | **Relation**(brother, half-brother, etc.) | **Date of Birth:** |
| **1** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **2** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **3** | Click here to enter text. | Click here to enter text. | Click here to enter text. |

SIBLINGS – currently living out of the house

|  |  |  |  |
| --- | --- | --- | --- |
| **Sib #** | **Name** | **Relation**(brother, half-brother, etc.) | **Date of Birth:** |
| **1** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **2** | Click here to enter text. | Click here to enter text. | Click here to enter text. |

CURRENT CHILD WELFARE INVOLVEMENT: YES[ ]  NO[ ]

|  |  |  |
| --- | --- | --- |
| **Family Worker** Click here to enter text.**:**  | **Ext:**### | **Agency Name & Phone #**Click here to enter text. |
| **Child Worker:**Click here to enter text. | **Ext:**### |
| **Resource Worker:**Click here to enter text. | **Ext:**### |
| **Is there a court/supervisory order?** Yes [ ]  No[ ]   N/A [ ]  | **Voluntary Agreement** Yes[ ]  No[ ]  N/A[ ] **(care by agreement)**  |
| **If child/ren out of home, how often is there parent contact? Are these visits supervised or unsupervised?**Click here to enter text.**Wardship Status:** Click here to enter text. | **Is family reunification part of the plan of care?** YES[ ]  NO[ ]  N/A[ ] Date: Click here to enter a date. |

BACKGROUND INFORMATION / CURRENT SITUATION

|  |  |
| --- | --- |
| **Home / Family Circumstances** | Click here to enter text. |
| **School** | Click here to enter text. |
| **Medical / Health** *incl. any documented diagnoses, disabilities and prescribed medications* | Click here to enter text. |
| **Peer Relations** | Click here to enter text. |
| **Criminal Activity** | Click here to enter text. |

TREATMENT HISTORY: *please mark an X beside all previous and current services and supports*

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **past** | **current** | **Contact Person / Comments** |
| Big Brothers of Sarnia-Lambton |[ ] [ ]  Click here to enter text. |
| Big Sisters of Sarnia-Lambton |[ ] [ ]  Click here to enter text. |
| Bluewater Health Addiction Services |[ ] [ ]  Click here to enter text. |
| Bluewater Health Mental Health Services |[ ] [ ]  Click here to enter text. |
| Canadian Mental Health Association |[ ] [ ]  Click here to enter text. |
| Children’s Aid Society |[ ] [ ]  Click here to enter text. |
| Community Health Services (Health Unit) |[ ] [ ]  Click here to enter text. |
| Community Living Sarnia-Lambton |[ ] [ ]  Click here to enter text. |
| C.P.R.I. |[ ] [ ]  Click here to enter text. |
| Family Counselling Centre |[ ] [ ]  Click here to enter text. |
| Huron House Boys’ Home |[ ] [ ]  Click here to enter text. |
| Inn of the Good Shepherd |[ ] [ ]  Click here to enter text. |
| Lambton County Developmental Services |[ ] [ ]  Click here to enter text. |
| L.K.D.S.B. Student / Behaviour Services |[ ] [ ]  Click here to enter text. |
| Pathways Health Centre for Children |[ ] [ ]  Click here to enter text. |
| Private Counsellor |[ ] [ ]  Click here to enter text. |
| Probation Services  |[ ] [ ]  Click here to enter text. |
| Psychologist |[ ] [ ]  Click here to enter text. |
| Psychiatrist |[ ] [ ]  Click here to enter text. |
| Rebound |[ ] [ ]  Click here to enter text. |
| Residential Placement |[ ] [ ]  Click here to enter text. |
| Special Services At Home |[ ] [ ]  Click here to enter text. |
| S.C.C.D.S.B. Student / Social Work Services |[ ] [ ]  Click here to enter text. |
| St. Francis Advocates |[ ] [ ]  Click here to enter text. |
| Women’s Interval Home |[ ] [ ]  Click here to enter text. |
| Other:Click here to enter text. |[ ] [ ]  Click here to enter text. |
| Click here to enter text. |[ ] [ ]  Click here to enter text. |
| Click here to enter text. |[ ] [ ]  Click here to enter text. |
| Click here to enter text. |[ ] [ ]  Click here to enter text. |

REASON FOR REFERRAL:

|  |
| --- |
| Click here to enter text. |

SUMMARY OF IDENTIFIED RISKS / NEEDS:

|  |
| --- |
| Click here to enter text. |

TOP THREE EXPECTED OUTCOMES:

|  |  |
| --- | --- |
| 1. | Click here to enter text. |
| 2. | Click here to enter text. |
| 3. | Click here to enter text. |