

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 Name  Click here to enter text. | **D.O.B** . Year/Month/Day  Click here to enter text. | | | **Gender**: Male  Female |
| **Address:** include postal code  Click 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 Name  Click here to enter text. | **D.O.B** . Year/Month/Day  Click here to enter text. | | | **Gender**: Male  Female |
| **Address:** include postal code  Click 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 Name  Click here to enter text. | **D.O.B.** Year/Month/Day  Click 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 Name  Click here to enter text. | **D.O.B.** Year/Month/Day  Click 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:

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| --- |
| 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. |