**Referral Form**

 I am referring myself Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I am submitting a referral on the behalf of the caregiver(s)

Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Protection program  Diversion program

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Caregiver(s) Name |  | | | | |
| DOB: mm-dd-yyyy |  | Marital Status | |  | |
| Partner Name |  | Partner DOB: | |  | |
| Street Address |  | City |  | | |
| Phone Number |  | Text only? | | |  |

Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Referral:** What do you feel a Family Support Worker could do for the family?

**Household Information:** Please list all individuals that are **living in the home** at the time of this application.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **DOB** | **Sex** | **Relationship to Caregiver** | **Other Factors** |
|  |  |  |  |  |
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|  |  |  |
| --- | --- | --- |
| Pregnant? | Estimated due date: |  |
| Pets in the home? |  |  |

Does family smoke in the home?

What other community supports/resources is the family connected to?

Is there a **history of violence and/or psychosis** for any member of the household?   
If yes, please explain in detail and specify which family member(s):

**For MSS only: Please provide a relevant summary below from the family’s Linkin history, including any investigations, child apprehensions, and previous Child Protection involvement. Please ensure not to include any identifiers when referencing calls made to Intake, as we wish to maintain confidentiality for all parties.**

**Family Information:**

Are you aware of any of the following issues (past or current)? If so, please elaborate and indicate which family member(s) the issue applies to. This information enables us to better match a support worker with the family, as well as assess an urgency rating for the family. Please be assured that **all information will be kept** **confidential.  
  
Please check if applicable:** Single Mom Teen Parent Grandparent Single Dad

Cognitive Limitations  
*(Circle: Child or Caregiver)*

Fetal Alcohol Exposure  
*(Circle: Child or Caregiver)*

ADHD  
*(Circle: Child or Caregiver)*

Mental Health  
*(Circle: Child or Caregiver)*

Autism  
*(Circle: Child or Caregiver)*

Health/Disability Concerns  
*(Circle: Child or Caregiver)*

|  |  |
| --- | --- |
|  |  |

Alcohol Use  
*(Circle: Past/Current)*

Substance Use  
*(Circle: Past/Current)*

On the Methadone Program

Family Violence  
*(Circle: Past/Current)*

No Contact Orders

Gang Affiliation

Child Abuse  
*(Please specify)*

Child Neglect  
*(Please specify)*

School/Daycare Attendance Issues

Children Running Away

Leaving Children Unsupervised

Inadequate Supervision

Physical Discipline

Yelling

Lacks Parenting Skills

Struggles with Child behaviour

Home cleanliness/safety

Unstable/Inadequate housing

Food security

Budget/Income struggles

Shared Custody   
 Child Protection Involvement (past/current)

**Expected Outcomes:**

Caregiver(s) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MSS or Agency Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For MSS only:**  
Please check time frame to readdress contracted outcomes:

1 month 3 months 6 months Other   
  
Please indicate total hours of support expected per week: \_\_\_\_\_\_\_hours

**Referrals can be emailed to:**

meagan@havenfamilyconnections.com

FOR OFFICE USE ONLY

|  |  |  |  |
| --- | --- | --- | --- |
| Received by: |  | Date: |  |