

## PARENT SUPPORT PROGRAM REFERRAL FORM

DATE OF REFERRAL: \_\_\_\_\_  
MONTH DAY YEAR

|                                                                                                                                                        |                                                                                                   |                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------|
| Client Name: _____                                                                                                                                     | Age: _____                                                                                        | Phone: _____                            |
| DOB: _____<br>MONTH DAY YEAR                                                                                                                           | Is this a First Nations or Metis client? <input type="checkbox"/> yes <input type="checkbox"/> no |                                         |
| Address: _____                                                                                                                                         | Postal Code: _____                                                                                |                                         |
| Custody Info: <input type="checkbox"/> 2 Parent <input type="checkbox"/> SP/mom <input type="checkbox"/> SP/dad <input type="checkbox"/> Child in care | Income Assistance: <input type="checkbox"/> yes <input type="checkbox"/> no                       |                                         |
| Partner's Name: _____                                                                                                                                  | Language Spoken at Home: _____                                                                    |                                         |
| Children: _____                                                                                                                                        | Gender: _____                                                                                     | Age: _____ DOB: _____<br>MONTH DAY YEAR |
| _____                                                                                                                                                  | Gender: _____                                                                                     | Age: _____ DOB: _____                   |
| _____                                                                                                                                                  | Gender: _____                                                                                     | Age: _____ DOB: _____                   |
| Others in the home: _____                                                                                                                              |                                                                                                   |                                         |
| Previous Cameray involvement? <input type="checkbox"/> yes <input type="checkbox"/> no Program and dates: _____                                        |                                                                                                   |                                         |

|                           |                                                                                                  |
|---------------------------|--------------------------------------------------------------------------------------------------|
| Source of Referral: _____ | Phone: _____                                                                                     |
| Position: _____           | Has family given consent to contact us? <input type="checkbox"/> yes <input type="checkbox"/> no |

|                                                                   |                                                                                                                  |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Newborn? <input type="checkbox"/> yes <input type="checkbox"/> no | If yes, Public Health visit within 2 weeks of referral? <input type="checkbox"/> yes <input type="checkbox"/> no |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|

Background Information / Comments / Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: (Please provide details.) Medication:  yes \_\_\_\_\_  no  
MCFD involvement:  yes Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_  
Mental Health involvement: \_\_\_\_\_  
Suicidality: \_\_\_\_\_  
Substance abuse: \_\_\_\_\_  
Other referrals made: \_\_\_\_\_

|                                                                                              |                                 |                                               |           |
|----------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------|-----------|
| Intake by: _____                                                                             | Referral No: _____              | Entered on Computer: <input type="checkbox"/> | By: _____ |
| Does referral fit program criteria? <input type="checkbox"/> yes <input type="checkbox"/> no | Approved by Co-ordinator: _____ |                                               |           |
| Date File Opened: _____                                                                      | Counsellor Assigned: _____      |                                               |           |