

FOSTER PARENT SUPPORT REFERRAL FORM

REQUIRED PROGRAMME:

- Foster Parent Support & Education-Requested level of support:
 Tier 1 In-home foster family caregiver support services
 Tier 2 Child & Youth Care Skill Development Worker
 Tier 3 Specialized in-home caregiver support
- Mental Health Caregiver Support Programme (formerly YRCS)
 FASD Key Worker Programme: Support Assessment

CAREGIVER INFORMATION:

Name:

Level of Caregiver: Restricted Level 1 Level 2 Level 3 Other:

Address:

Phone Number:

E-mail Address:

of children/total beds in home:

Has foster parent completed mandatory training: Yes No

Agency: MCFD VACFSS

RESOURCE WORKER INFORMATION:

Name:

Agency: MCFD VACFSS

Office Code:

Phone Number:

Fax Number:

E-mail Address:

SOCIAL WORKER INFORMATION:

Name:

Agency: MCFD VACFSS

Office Code:

Phone Number:

Fax Number:

E-mail Address:

CHILD/YOUTH INFORMATION:

Name:

Date of Birth:

Date of Placement in Home:

School Attending:

Grade:

Physician's Name:

WHICH IF ANY OF THE FOLLOWING HAS CHILD/YOUTH BEEN DIAGNOSED WITH:

- | | |
|--|--|
| <input type="checkbox"/> ADHD (Attention Deficit Hyperactivity Disorder) | <input type="checkbox"/> ADD (Attention Deficit Disorder) |
| <input type="checkbox"/> RAD (Reactive Attachment Disorder) | <input type="checkbox"/> FAS (Fetal Alcohol Syndrome) |
| <input type="checkbox"/> FAE (Fetal Alcohol Effect) | <input type="checkbox"/> OCD (Obsessive Compulsive Disorder) |
| <input type="checkbox"/> Conduct Behaviour | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Other (specify: _____) |

WHICH IF ANY OF THE FOLLOWING ASSESSMENTS HAVE BEEN COMPLETED:

(Please include assessments with referral)

Assessment	Person/Agency Responsible & Completion Date
<input type="checkbox"/> Psych-ed	
<input type="checkbox"/> Cognitive	
<input type="checkbox"/> CAFAS	
<input type="checkbox"/> Speech/Language	
<input type="checkbox"/> Woodcock-Johnson	
<input type="checkbox"/> Other	

PLEASE INDICATE WHICH OF THE FOLLOWING SERVICES ARE CURRENTLY ACTIVE:

Service	Required	Active	Service Provided By
One-to-One Worker	<input type="checkbox"/>	<input type="checkbox"/>	
Respite	<input type="checkbox"/>	<input type="checkbox"/>	
School/Day Program	<input type="checkbox"/>	<input type="checkbox"/>	
Caregiver Support Group	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatrist or Mental Health Team	<input type="checkbox"/>	<input type="checkbox"/>	
Other Support Services	<input type="checkbox"/>	<input type="checkbox"/>	

SPECIFIC STRENGTHS OF CAREGIVER:

1. _____
2. _____
3. _____

SPECIFIC GOALS TO BE ADDRESSED BY SUPPORT SERVICES:

(In addition to providing support and preventing breakdown)

1. _____
2. _____
3. _____

OTHER RELEVANT INFORMATION:

Caregiver Signature: _____ Date: _____

Resource Worker Signature: _____ Date: _____

For referral table use only:

Tier: 2 3 CYCDW Agency: _____ Date: _____

Recommendations: _____