



Guardianship & Residential Resources
 2nd floor - 3284 E. Broadway
 Vancouver, BC V5M 1ZB
 Tel: 604-216-6100
 www.vacfss.com



Hollyburn Family Services

203 – 585 16th Street, West Vancouver, BC V7V 3R8
 Tel: 604-926-1185 Fax: 604-926-1134
 www.hollyburn.ca

FOSTER PARENT SUPPORT REFERRAL FORM

Required Programme

- Foster Parent Support – Request Level of Support
 - Category 2 – Generalized Services
 - Welcome Wagon
 - Psychological Consultation
 - Category 3 – In-Home Support Services
 - Out of Care Family
 - Child/Youth Skill Development Worker
- Mental Health Caregiver Support Program FACES
- FASD Key Worker Support Assessment

Caregiver Information

Name	
Level of Caregiver	<input type="checkbox"/> Restricted <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 Other:
Address	
Phone Number	
Email Address	
# of Children/Total Beds in Home	
Has Foster Parent Completed Mandatory Training	<input type="checkbox"/> Yes <input type="checkbox"/> No
Agency	<input type="checkbox"/> VACFSS

Resource Worker Information

Name		
Phone Number		Fax Number:
Email Address		

Social Worker Information

Name		
Phone Number		Fax Number:
Email 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"/> FAX (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"/>	
Psychological Consult	<input type="checkbox"/>	<input type="checkbox"/>	
CYSD Worker	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<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 prevention breakdown)**

1.
2.
3.

Other Relevant Information

Caregiver Signature: _____ Date: _____

Resource Worker Signature: _____ Date: _____

Acceptance of Referral Signature: _____ Date: _____

For referral table use only: <input type="checkbox"/> Category 2 <input type="checkbox"/> Category 3 <input type="checkbox"/> CYSDW <input type="checkbox"/> Welcome Wagon <input type="checkbox"/> OOC <input type="checkbox"/> Mental Health <input type="checkbox"/> FASD Worker Agency: _____ Date: _____

Recommendations: _____ _____ _____
--