FAMILY REFERRAL FORM

CHILDREN'S RESOURCE COUNCIL – FAMILY RESOURCE NETWORK

FAX TO: 780-523-4117 or EMAIL TO: hpdcrc@telus.net

Referring Agency/Hospital: _____ Date: _____

Screen/Referral Completed by: _____ Request call back: _____

Partner/Mother's Name: _____ Partner/Father's Name: _____

Birth Date: _____ Birth Date: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Information	Child	Child	Child
Name & Preferred Pronoun			
Date of Birth			
Current Diagnosis / Health Concerns			
Up-to-Date Immunizations & Date			

Conditions		
	1	Marital Status – single, parenting alone
	2	Income – inadequate income, partner unemployed
	3	Housing – unstable
	4	Communication – no phone
	5	Education – less than high school completion
	6	Substance abuse – history / current
	7	Maternal Health – late prenatal care, NPC or contact with physician, considered ending pregnancy.
	8	Maternal Knowledge – concern regarding mother's / parent's ability to understand and use skills needed to care for baby.
	9	Mental Health – history of psychiatric care, mental health issues, depression, addiction issues
	10	Age – under 20 years
	11	Health – concerns for mother / infant, nutrition or breastfeeding issues, presence of child disability or delay
	12	Family Crisis - relationship issues, family violence
	13	Isolation – social / geographically isolated, new to community, no transportation
	14	Recent immigrant, refugee or language minority, Indigenous (FNMI)
	15	Child maltreatment - history / current child abuse or neglect, Children's Service involvement

_____ (Initial) CONSENT given to share contact information with the High Prairie & District Children's Resource Council / Family Resource Network regarding services available.

_____ (Initial) CONSENT given to be contacted by the High Prairie & District Children's Resource Council / Family Resource Network to receive support services.

Information of Additional Children	Child	Child	Child
Name			
Date of Birth			
Current Diagnosis / Health Concerns			
Up-to-Date Immunizations & Date			

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FOR OFFICE USE ONLY:

Positive For Early Intervention / Intervention if:

1 – Yes to 1, 7, 8, 10, 11, 12, 15

2 – 3 or more factors present. (Also, eligible for nutritional supports.)

3 - 5+ unknowns

ALL Positive Screens proceed to voluntary early intervention and parent survey assessment.

☐ **Client AGREES to be involved in Early Intervention / Health Services provided by HPDCRC.**

☐ **Client DECLINED to be involved in Early Intervention / Health Services provided by HPDCRC.**

Navigation:

☐ Referred to other program / spoke: _____

☐ CRC Placement:

	FRN HUB	CAPC	CPNP	ST	BFNS	CHARITY
Primary Supports Service Domain	☐ Child Development and Well-being ☐ Caregiver Capacity Building ☐ Social Connections & Supports	☐ Child Development and Well-being ☐ Caregiver Capacity Building ☐ Social Connections & Supports	☐ Child Development and Well-being ☐ Caregiver Capacity Building ☐ Social Connections & Supports	☐ Child Development and Well-being ☐ Caregiver Capacity Building ☐ Social Connections & Supports	☐ Child Development and Well-being ☐ Caregiver Capacity Building ☐ Social Connections & Supports	☐ _____
Continuum of Service Recommended	☐ Universal/ Preventative ☐ Targeted/Early Intervention ☐ Intensive/ Intervention	☐ Universal/ Preventative ☐ Targeted/Early Intervention ☐ Intensive/ Intervention	☐ Universal/ Preventative ☐ Targeted/Early Intervention ☐ Intensive/ Intervention	☐ Universal/ Preventative ☐ Targeted/Early Intervention ☐ Intensive/ Intervention	☐ Universal/ Preventative ☐ Targeted/Early Intervention ☐ Intensive/ Intervention	☐ Preventative ☐ Early Intervention ☐ Intensive/ Intervention
Service Area	☐ SR ☐ BLC ☐ LSR ☐ O ☐ EP. P, GL ☐ Other: _____	☐ BLC ☐ EP. P, GL ☐ Other: _____	☐ BLC ☐ EP. P ☐ Other: _____	☐ SR ☐ BLC ☐ LSR ☐ O ☐ Other: _____	☐ SR ☐ BLC ☐ LSR ☐ O ☐ Other: _____	☐ SR ☐ BLC ☐ LSR ☐ O ☐ EP. P, GL ☐ Other: _____

Referral Received by / Date:_____ **Screen Reviewed by:** _____

Contact made by / Date: _____ **Gift Delivery by / Date:** _____----_____

Service Intake by / Date: _____