

**Alderwood Family Development Centre**  
**2750 East 18th Vancouver V5M 4W8**  
**Phone: 604-434-9101 | Fax: 604-434-9938**  
 www.childrens foundation.org | sharon.lund@childrens foundation.org

Referring Person's Name, Role and Organization:	Phone Number:	Email:
Date:		

**Section I - Child and Family Information**

Legal Name in Full:	Known as:	D.O.B:	Gender:	Care Card#:
Primary Caregiver(s) (Name of Person(s) Child Lives With:			Relationship to Child:	
			Legal Guardian:	YES
Address:		Postal Code:	Home Phone:	Work Phone:
Parents Name (If Different from Above)			Contact Restrictions:	
Address:		Postal Code:	Home Phone:	Work Phone:
Parent Living Elsewhere:	Address:			Postal Code:
Involved with Child?	YES	NO	Home Phone:	Work Phone:
Is MCFD Involved?:	YES	NO	Social Worker Name:	Social Worker Telephone:

**Section II - Reasons For Referral**

Give a Brief Description of the Reason for this Referral. In Particular, why now?

Strengths	Needs/Concerns
Please List Strengths Regarding the Child:	List Specific Emotional and Behavioural Issues Regarding the Child (E.G. Anxiety Versus Hitting)

### Section III - Child's Functioning

Check the Box Below which Indicates the Degree of Difficulty the Child is having in Each Area:

	Low	Medium	High	Comments:
1. Home				
2. School				
3. Community				

### Section IV - Education Information

School Name:	Address:	Postal Code:
Phone:	Fax:	
Type of Classroom Setting:	Classroom Aid?:	Grade Completed:
Describe Learning Difficulties:		
Is there a Medical Exclusion in Place? YES                      NO		Date Last Attended:
Professionals at the School:	Role:	Phone Number:

### Section V - Health Information

Child's Family Doctor (GP):	Telephone:
Other Physical or Health Professional:	Telephone:
Allergies:	

## Mental Health Information:

Safety Is this Child at Risk for Deliberate:	Risk Only	Already Attempted?
1. Self Harm?	YES      NO	YES      NO
2. Suicide?	YES      NO	YES      NO
3. Harm to Others?	YES      NO	YES      NO

Is there a Mental Health Team Involved? Please List Below:	Is there a Psychiatrist Involved? Please List Below:
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Mental Health Team Phone:	Psychiatrist Phone:
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Any Formal Diagnoses:	Diagnosis Given By:
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1.	1.
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2.	2.
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Current Medications For Mental Health Reasons:	Prescribed By:
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1.	1.
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2.	2.
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3.	3.
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## Section VI - Family Information

1. What Language is Spoken at Home?:	2. Does the Family Need an Interpreter? <div style="text-align: center;">YES                      NO</div>
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3. Are there any Cultural Factors that may Affect Service Delivery?:
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4. Are Parent(s) Aboriginal?  <div style="text-align: center;">YES              NO</div> Is Child Aboriginal?  <div style="text-align: center;">YES              NO</div>	5. If so, are they:  <div style="text-align: center;">First Nations      YES      NO</div> <div style="text-align: center;">Metis                      YES      NO</div> <div style="text-align: center;">Inuit                      YES      NO</div>	6. What is the Band Affiliation?
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7. Please List and Date Major Life Events which seem to be Greatly Impacting Family (e.g. Movies, Marriages, Separations, Losses, Births):
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## Section VII - Current Professionals and Service Providers

Agency Name:	Contact Person:	Phone Number:

## Section VIII - Reports and Assessments

Are these Report Items Attached to the Referral?

Report Item	YES	NO	Or Pending?
IEP School Report			
Speech/Hearing Report			
Medications List			
Psychiatric Report			
Medical Report			
Psychology Report			
Assessments			



**Alderwood Family Development Centre is a Partnership Program Between  
Vancouver School Board, Vancouver Coastal Health, Ministry of Children  
and Families and The Children's Foundation**