THE CHILDREN'S FOUNDATION

Centre for Childhood Neurodevelopment, Education and Family Wellbeing

www.childrens foundation.org | familywellness@childrens foundation.org

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

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 Physicial 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:
Mental Health Team Phone:	Psychiatrist Phone:
Any Formal Diagnoses:	Diagnosis Given By:
1.	1.
2.	2.
Current Medications For Mental Health Reasons:	Prescribed By:
1.	1.
2.	2.
3.	3.

Section VI - Family Information

1. What Language is Spoken at Home?:	2. Does the Family Need an Interpreter? YES NO

3. Are there any Cultural Factors that may Affect Service Delivery?:

4. Are Parent(s) Aboriginal?	5. If so, are they:	6. What is the Band Affiliation?
YES NO	First Nations YES NO	
Is Child Aboriginal?	Metis YES NO	
YES NO	Inuit YES NO	

7. Please List and Date Major Life Events which seem to be Greatly Impacting Family
(e.g. Movies, Marriages, Separations, Losses, Births):

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?

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

The Centre for Childhood Neurodevelopment is a Partnership Program with the Ministry of Children and Families, Surrey School Board, Fraser Health and The Children's Foundation