

CEDARWOOD Screening Tool for families with OPEN MCFD file: for considering Cedarwood Family Program Referrals.

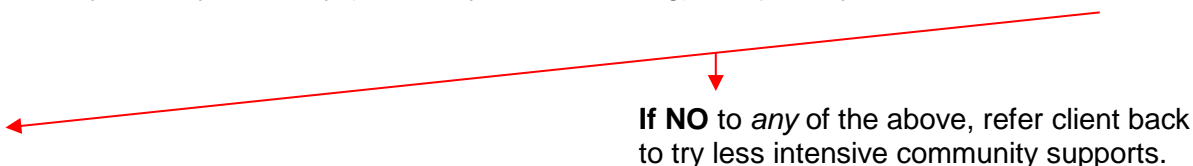
Note: Ask client whatever questions you need to, to determine the likely answer to each item below.

If in doubt, consult with the MCFD CEDARWOOD liaison or with CEDARWOOD directly. This list reflects CEDARWOOD policy, but exceptions may be warranted.

Item:

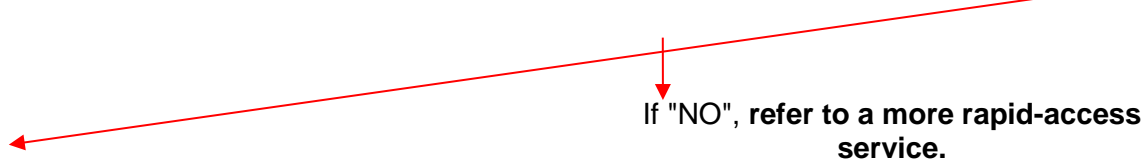
Circle YES or NO:

1. Is child 12.0 years of age or less? Yes / No
2. Has the behaviour problem been going on a long time (e.g. over 6 months)? Yes / No
3. Are behaviour problems more than a reaction to a specific event/situation? Yes / No
4. Are problems likely to threaten the stability of the home or school placement, or the child's well being (but primarily non-protection)? Yes / No
5. Have less intensive community helpers been tried, including physician? Yes / No (For example: school counsellor, CHADD, Parents Together, church, relatives)
6. Does family have the motivation and the means to attend at least one appointment weekly, usually in Surrey (some day, some evening) for up to 1 year? Yes/No



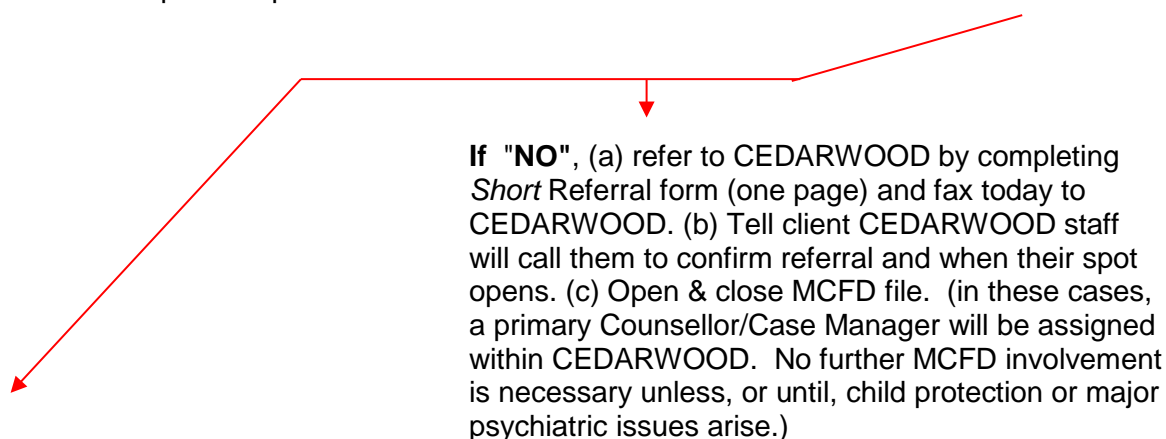
If "YES" to all, continue:

7. Can the family safely wait for CEDARWOOD services to become available? (CEDARWOOD is not able to be an emergency service) Yes / No



If "YES", then this is an appropriate referral to CEDARWOOD; please continue:

9. Will MCFD keep a file open after referral to CEDARWOOD is made? Yes / No



Lastly, if "YES": (a) Do full length CEDARWOOD Referral form and fax to Cedarwood Supervisor (currently Zdeno Rusnak 778-395-3327) for prioritization for CEDARWOOD waitlist. (b) Have an MCFD file opened. Primary case manager assigned within MCFD.

MCFD File staying Open Yes__ No__ MCFD Multi-Disciplinary Team CYMH

MCFD Social Worker / CYMH Clinician:	Date completed:	District office:
Mailing Address:	Telephone :	Fax:
	Email:	

Section 1 Child (Case name)

Legal name (in full)	Known as:	D.O.B.	Gender:
Primary Caregiver/Guardian:	Child Legal Status		
Address & postal code:	Home Phone:	Work phone:	
Email:	D.O.B.		
Is there a current custody dispute?			
Approx. date of next hearing/court review			
What type of custody agreement is in place?			
Is there a court order mandating counselling for the child?			

Section 2: Family members

Partner's name		Address		
D.O.B.	Involved Yes__ No__	Home Phone	Work phone	
Parent living elsewhere		Address		
D.O.B.	Involved Yes__ No__	Home Phone	Work phone	
Other family members				
Name	Relationship to child	In Home?	D.O.B.	Available
		Y / N		Y / N
		Y / N		Y / N
		Y / N		Y / N
		Y / N		Y / N
		Y / N		Y / N

Section 3: Safety Concerns

FAMILY OR CHILD HAS A HISTORY OF (please check each that apply):				
DRUGS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
ALCOHOL	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
VIOLENCE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
SUICIDE/SUICIDE IDEATION	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
MENTAL ILLNESS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
MEDICAL RISK	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
HOSPITALIZATIONS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
OTHER (SPECIFY	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
IS THERE DOCUMENTATION OF:				
MOTIVATION – family wants help?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
Is family required to attend CFP?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
Abuse – Sexual	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
Abuse – Physical	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
Abuse – Neglect	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
Criminal Charges	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO /	WHEN
DESCRIBE NATURE OF ANY “YES” ABOVE:				

Section 4: Reason for Referral

GIVE A BRIEF DESCRIPTION OF THE NUMBER ONE PRIORITY CHALLENGES (UNRESOLVED ISSUES) (why referral now):	
1)	MAIN CHILD CHALLENGES (UNRESOLVED ISSUES)?
2)	MAIN FAMILY CHALLENGES (UNRESOLVED ISSUES)?
3)	OTHER HABITS, ATTITUDES, BEHAVIOURS (eg: bed wetting, soiling, tics):

Section 5: Current and past referrals:

HAS THE FAMILY BEEN TREATED AS A UNIT BEFORE					Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
IS THE CHILD AT RISK TO COME IN CARE NOW					Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
OTHER CURRENT SERVICES		PHONE NUMBER		CONTACT NAME				
1)								
2)								
3)								
4)								
Past professionals								
OFFICE:	NAME:	ADDRESS:	TELEPHONE	WHEN (include prev placements):				
WHOSE IDEA WAS THE CFP REFERRAL?				HOW LONG HAS MCFD BEEN INVOLVED?				

Section 6: Collateral Reports

INFO ITEM	ENCLOSED		AVAILABLE		INFO ITEM	ENCLOSED		AVAILABLE	
SCHOOL REPORTS	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	MEDICAL REPORT	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
MEDS LIST	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	PSYCHOLOGIST	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
PSYCHIATRIC	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	PROBATION	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
SPEECH / HEARING	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	OTHER (specify)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

Section 7: Medical Information

CHILD'S DOCTOR (GP):	TELEPHONE:	CHILD'S SPECIALIST: (please specify)	TELEPHONE:
IMMUNIZATION UP TO DATE: Y / N	MEDICATIONS:		
PAST SIGNIFICANT DISEASES AND CURRENT HEALTH CONCERNS (eg: allergies, diet, etc.):			
PHYSICAL DESCRIPTION AND HEALTH OF CHILD:			

PLEASE SKETCH A SIMPLE GENOGRAM BELOW (mention losses, conflicts, close bonds – to whom?)

Section 11: Anticipated transition and Closing Planning

AGENCIES AND/OR SERVICES EXPECTED TO BE NEEDED AFTER CLOSING WITH CEDARWOOD
1.
2.
3.