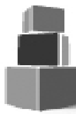
The Children's Foundation


CEDARWOOD FAMILY PROGRAM
#1000 (10th Floor) 13737-96 Ave., Surrey, BC V3V 0C6
Phone: 778-945-1690 Fax: 778-395-3327

Cedarwood Screening Tool for families with NO 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 Cedarwood Clinical Supervisor (currently Zdeno Rusnak).
This list reflects Cedarwood policy, but exceptions may be warranted.

Item: **Circle YES or NO:**

1. Is child 11.0 years of age or less? .... Yes / No
2. Has 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 wellbeing (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) up to 1 year? .... Yes/No

If NO to *any* of the above, refer client back to try less intensive community supports.

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 "NO", refer to a more rapid-access service.

If "YES", then this is an appropriate referral to Cedarwood. Refer to Cedarwood by completing the Short Referral (one page) and fax to Cedarwood. Tell client CEDARWOOD staff will call them to confirm referral and when their spot opens. No further MCFD involvement is necessary unless, or until, child protection or major psychiatric issues arise.

COMMUNITY REFERRAL FORM FOR CEDARWOOD FAMILY PROGRAM

(For use when MCFD will not keep a file open).

Fax to:	CEDARWOOD Supervisor (604) 778-395-3327	Total Pages:	Date:

Referring MCFD Worker:	MCFD Office:	Phone:	Fax:
CEDARWOOD First Suggested to Family by:		Email:	

Child's Last Name:	Child's First Name:	Gender: M / F

Telephone:	Address:	Postal Code:	D.O.B.

Parent/ Guardian Surname:	First Name:	Relationship:

Home Telephone: Email:	Work Telephone: D.O.B.

Caregiver (if not Guardian):	First Name:	Relationship:

Home Telephone:	Work Telephone:

Parent Living Elsewhere? Yes / No	Name:	D.O.B.	Involved? Yes / No

Address:	Home Telephone:	Work Telephone:

Siblings and D.O.B.

School:	Grade:	Phone:

Involved Professionals:

Doctor:	Phone:	
Current Medication:		Diagnosis if known:

Current Problems: (Please be specific re: nature and duration of the main problem)

Expectations: (i.e.: (1) of family? (2) Of referring worker? (3) Of community professionals involved?)

(1)

(2)

(3)

Other Information: (Information attached Y / N)?