

Cedarwood Langley Family Program Referral Form



CEDARWOOD LANGLEY FAMILY PROGRAM
5-20461 Douglas Crescent, Langley, B.C. V3A 4B6
Phone: 778-777-5025 Fax: 778-777-5024

MCFD File staying open YES NO

REFERRAL TO CEDARWOOD

This form to be used when a MCFD file will remain open.

MCFD SOCIAL WORKER:	DATE COMPLETED:	DISTRICT OFFICE:	
MAILING ADDRESS:		TELEPHONE:	FAX:

SECTION I – CHILD (Case Name)

LEGAL NAME IN FULL:	KNOWN AS:	D.O.B.:	GENDER:	CARE CARD NUMBER:
GUARDIAN(s):		CHILD LEGAL STATUS:		APPROX DATE OF NEXT HEARING/COURT REVIEW
D.O.B.:				
ADDRESS & POSTAL CODE:			HOME PHONE:	WORK PHONE:
PRIMARY CAREGIVER(s): (if different)		D.O.B.	RELATIONSHIP TO CHILD:	MARITAL STATUS:
ADDRESS & POSTAL CODE:			HOME PHONE:	WORK PHONE:

SECTION II – FAMILY MEMBERS (Or Significant Adults)

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
		Y / N		Y / N
		Y / N		Y / N

SECTION III – 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.):			

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PHYSICAL DESCRIPTION AND HEALTH OF CHILD:

SECTION IV – SCHOOL RECORD AND INTERESTS/SKILLS

SCHOOL NAME:	ADDRESS:	DATE LAST ATTENDED:	GRADE FINISHED:	I.E.P. DONE:	SCHOOL PROBLEMS:
				<input type="checkbox"/> YES	<input type="checkbox"/> MILD
				<input type="checkbox"/> NO	<input type="checkbox"/> MODERATE
				<input type="checkbox"/> PENDING	<input type="checkbox"/> SEVERE
STUDENT'S INTERESTS/SKILLS:				REGULAR CLASS?	
SOCIAL DEVELOPMENT OR "B.D." CLASS?			SCHOOL AID / S.E.A./C.C.W.?		
MAIN SCHOOL DIFFICULTY:					
SCHOOL PHONE:			COUNSELLOR'S NAME:		
SCHOOL FAX:			CLASSROOM TEACHER:		
OTHER SCHOOL CONTACTS OR INFO:					

SECTION V – GOALS FOR FAMILY

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SECTION VI – CHILD’S PERSONAL INFORMATION

SPECIAL INTERESTS OF CHILD (hobbies, sports, standing commitments, etc., not school related):

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	_____
VIOLENT	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO / WHEN	_____
SUICIDAL	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:

c MOTIVATION – family wants help?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	WHO / WHEN	
Is family required to attend BFP?	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 VII – DESCRIBE SERVICES CURRENTLY PROVIDED TO THE CHILD/FAMILY (in addition to list in Section III)

HAS THE FAMILY BEEN TREATED AS A UNIT BEFORE YES NO

IS THE CHILD AT RISK TO COME IN CARE NOW YES NO

OTHER CURRENT SERVICES	PHONE NUMBER	CONTACT NAME
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1)		
2)		
3)		
4)		

SECTION VIII – PAST PROFESSIONALS (Agencies/Placements Involved)

OFFICE:	NAME:	ADDRESS:	TELEPHONE:	WHEN (include prev placements):

WHOSE IDEA WAS THE CFP REFERRAL?	HOW LONG HAS MCFD BEEN INVOLVED?
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	Signature of CYMH team leader
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