COMPLEX CARE / KEY WORKER PROGRAM

Contact us at 604-434-9101

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The Alderwood Complex Care / Key Worker Program supports children up to 19 years old and their families living the impacts of Fetal Alcohol Spectrum or Complex Neurodevelopment Conditions.

The Children's Foundation

COMPLEX CARE / KEY WORKER PROGRAM

ALDERWOOD – EXPANDING THE CIRCLE: 2750 EAST 18TH AVENUE VANCOUVER, BC V5M 4W8
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ELIGIBILITY CRITERIA:

IS THE PARENT AWARE OF REFERRAL?: YES □ NO □	HAS THE PARENT AGREED TO PARTICIPATE?: YES □ NO □

REFERRALS TO THE ALDERWOOD PROGRAM CAN BE MADE BY:
A ¥MCFD SOCIAL WORKER *B €YMH CLINICIAN* *C ¥VACFSS SOCIAL WORKER*

DATE OF REFERRAL:	REFERRING ORGANIZATION: MCFD/PROTECTION □ CYMH □ VACFSS □	REFERRING PERSON'S NAME AND ROLE:
REFERRING PERSON'S EMAIL ADDRESS:		REFERRING PERSON'S PHONE NUMBER:

SECTION I – CHILD AND FAMILY INFORMATION

CHILD NAME:		CHILD DATE OF BIRTH (MM-DD-YYYY):	
PRIMARY CAREGIVER(S) (NAME OF PERSON CHILD LIVES WITH):	RELATIONSHIP TO CHILD:	LEGAL GUARDIAN?: YES □ NO □	PARENT(S) DATE OF BIRTH:
ADDRESS:		HOME PHONE:	WORK PHONE:
PARENTS (IF DIFFERENT FROM ABOVE):		CONTACT RESTRICTIONS:	
ADDRESS:		HOME PHONE:	WORK PHONE:
PARENT LIVING ELSEWHERE:		ADDRESS AND POSTAL CODE:	
INVOLVED WITH CHILD?: YES □ NO □		HOME PHONE:	WORK PHONE:
IS____INVOLVED?: MCFD □ CYSN □ CYMH □ VACFSS □			SOCIAL WORKER TELEPHONE:
ARE THERE ANY CULTURAL FACTORS THAT MAY AFFECT SERVICE DELIVERY?:			

ARE PARENT(S) INDIGENOUS?: YES □ NO □ IS CHILD INDIGENOUS?: YES □ NO □		IF SO, ARE THEY: FIRST NATIONS?: YES □ NO □ METIS?: YES □ NO □ INUIT?: YES □ NO □	BAND AFFILIATION:
WHAT LANGUAGE IS SPOKEN AT HOME?	DOES THE FAMILY NEED A TRANSLATOR?: YES □ NO □	RESIDENCY IN BC: ☐ LESS THAN 1 YEAR ☐ 1-YEAR OR MORE ☐ UNKNOWN	RESIDENCY IN CANADA: ☐ CITIZEN ☐ PERMANENT RESIDENT ☐ LANDED IMMIGRANT

SECTION II – REASONS FOR REFERRAL

GIVE A BRIEF DESCRIPTION OF THE REASON FOR THIS REFERRAL. IN PARTICULAR, WHY NOW? IS THERE ANYTHING ELSE WE NEED TO KNOW?

PLEASE DESCRIBE HOW THE FAMILY WOULD LIKE TO BE SUPPORTED: (CHECK ALL THAT APPLY):

□ PARENTING SUPPORT AND EDUCATION
□ SELF REGULATION
□ HOUSING SECURITY
□ PARENT COACHING
□ STRESS MANAGEMENT
□ TRANSPORTATION
□ NAVIGATION AND ADVOCACY
□ FOOD SECURITY
□ CHILDREN'S GROUPS FOR SELF-REGULATION AND SKILLS DEVELOPMENT

STRENGTHS	NEEDS/CONCERNS
PLEASE LIST STRENGTHS REGARDING THE CHILD:	LIST SPECIFIC EMOTIONAL AND BEHAVIOURAL ISSUES RE: CHILD (I.E. ANXIETY versus HITTING):

SECTION III – CHILD'S FUNCTIONING

CHECK THE BOX BELOW WHICH INDICATES THE DEGREE OF DIFFICULT 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:
CURRENT GRADE:	TEACHERS NAME:	PHONE NUMBER:	IS THERE A MEDICAL EXCLUSION IN PLACE? YES □ NO □

IS THE CHILD IN SCHOOL: □ FULL-TIME □ PART-TIME □ NOT-ATTENDING	DATE LAST ATTENDED IF NOT- ATTENDING:

SECTION V – HEALTH INFORMATION

CHILD'S FAMILY DOCTOR (GP):	TELEPHONE:

ALLERGIES:

MENTAL HEALTH INFORMATION	SAFETY: IS THIS CHILD AT RISK FOR DELIBERATE:	RISKS 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 CYMH INVOLVED? YES □ NO □	IF YES, CYMH WORKER'S NAME AND PHONE NUMBER:
IS THERE A PSYCHIATRIST INVOLVED? PLEASE LIST BELOW:	PSYCHIATRIST PHONE:
FORMAL DIAGNOSIS:	DIAGNOSIS GIVEN BY:
1.	1.

2.	2.
CURRENT MEDICATIONS FOR MENTAL HEALTH REASONS:	PRESCRIBED BY:
1.	1.
2.	2.

SECTION VI – CURRENT PROFESSIONALS AND SERVICE PROVIDERS

AGENCY NAME:	CONTACT PERSON:	PHONE NUMBER:

SECTION VII – REPORTS AND ASSESSMENTS

ARE THESE REPORT ITEMS ATTACHED TO THE REFERRAL?:

IEP SCHOOL REPORT	YES ☐	NO ☐	MEDICAL REPORT	YES ☐	NO ☐
SPEECH/HEARING REPORT	YES ☐	NO ☐	PSYCHOLOGY REPORT	YES ☐	NO ☐
PSYCHIATRIC REPORT	YES ☐	NO ☐	OT ASSESSMENTS:	YES ☐	NO ☐