



Referral for Services – Outreach Support Services

Forward completed referral to the PACE Program:
Fax: 604-266-3041 Email: admin@thepaceprogram.ca Attention: Intake Team

- SUPPORT REQUESTED:**
- Child Specific Contract** *(complete sections 1-7, 9-11)*
 - General Contract** *(complete sections 1, 8-11)*
 - Short Term Consultation** - 1 or 2 visits
(complete sections as noted above – for either child specific or general consultation)

PREFERRED DAY & TIME FOR SUPPORT:

DAY Please note: we will try to accommodate your preference, however due to the demand for service, it may not be possible.	PREFERRED TIME (a.m. / p.m.)
1. <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	
2. <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	
3. <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	

SECTION 1: Referral Information – CENTRE

CENTRE / PROGRAM INFORMATION:

Program Name:			
Address:			
Phone:	FAX:	EMAIL:	
Supervisor:			
Primary Contact:			
Staff:			
Type of Board / Management:			
Contact Name:			
Phone:	Fax:	Email:	
Licensing Consultant:		Phone:	
Hours of Operation:		Holidays closed:	
Staff Meeting Times:			
Vancouver Network:		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	
Richmond <i>(please indicate area)</i>			
Inclusion Contract:	<input type="checkbox"/> Yes <input type="checkbox"/> No	For How Many Children?	Parent Involvement in Centre? <input type="checkbox"/> Yes <input type="checkbox"/> No

DEMOGRAPHICS OF CENTRE:

Number of Children Centre is Licensed for:		Number of Boys in Center:		Number of Girls in Centre:	
Number of Children Registered in Centre:		Number of Children with Significant Additional Needs:		Number of Children with Emotional / Behavioural Challenges:	
Number of infants – birth to 18 months:		Number of toddlers – 18 months to 3 years:		Number of 3 year olds:	
Number of 4 year olds:		Number of 5 year olds:		Number of 6 year olds:	
Number of 7/8 year olds:		Number of 9/10 year olds:		Number of 11/12 years:	

ETHNICITY OF CHILDREN:

<input type="checkbox"/> Aboriginal band/s :	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other: Please list
Languages Spoken:				
Total number of children ESL:		Number of those full time:		Number of those part time

ETHNICITY OF STAFF:

<input type="checkbox"/> Aboriginal band/s :	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other: Please list
Languages Spoken:				

SECTION 2: Referral Information – CHILD

Note: To be completed for Child Specific Consultation / Contracts.

If completing referral for General Contract/Consultation, please go to “SECTION 8”.

Child’s Legal Name:		Date of Birth:	
Child Known As:		Gender:	

Address:				
Primary Caregiver:		Relationship to child:		
Primary Caregiver:		Relationship to child:		
Language(s) Spoken:		Emergency Contact #:		
Home #:		Work #:	Cell #:	
<i>Others in the home?</i>		Sibling?	Gender	Age
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Household Composition:

<input type="checkbox"/> Single Parent	<input type="checkbox"/> Couple	<input type="checkbox"/> Co-Parenting	<input type="checkbox"/> Extended Family
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Ethnicity of Household Composition:

<input type="checkbox"/> Aboriginal:	<input type="checkbox"/> Caucasian	<input type="checkbox"/> South Asian	<input type="checkbox"/> Other -
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Ethnicity of Child:

<input type="checkbox"/>	Aboriginal – band:	<input type="checkbox"/>	Caucasian	<input type="checkbox"/>	South Asian	<input type="checkbox"/>	Other -
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Ethnicity of Parent:

<input type="checkbox"/>	Aboriginal – band:	<input type="checkbox"/>	Caucasian	<input type="checkbox"/>	South Asian	<input type="checkbox"/>	Other -
If immigrant, where from?		Describe any cultural factors that may affect service delivery:					

Custodial Status of Child Referred – if birth parent/s not primary caregiver or legal guardian:

Legal Guardian:		Child's Legal Status:	
Expiry of Legal Status:		Date of Next Review / Court:	
Parent Contact with Child? <input type="checkbox"/> Yes <input type="checkbox"/> No		Frequency:	Restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3: Reason(s) For Referral – CHILD SPECIFIC CONTRACTS

Presenting issues/risk factors, current & specific information (i.e. safety concerns, behavioural challenges, social and/or emotional challenges, changes in family, mental health issues, cognitive issues, multiple issues, placement breakdown, impending changes / recent events etc.)

1.	
2.	
3.	
4.	

SECTION 4: Child & Family History - Please indicate any key issues such as moves, separations, loss, apprehensions, trauma. Please indicate dates, where possible.

1.	
2.	
3.	
4.	
5.	

SECTION 5: Child's Strengths, Needs, Concerns - please list

<i>Please list strengths and skills regarding the child:</i>	<i>List specific emotional and/or behavioural issues re: child (e.g. anxiety, aggression) and known events/factors</i>	<i>Please list any other needs/concerns regarding child at this time:</i>

SECTION 6: Previous Program(s) &/or Therapy i.e. school history, child therapy

Program/Resource:	From When to When:	Contact Person and Phone #:

Are there any reports being forwarded – please list Yes No Unknown

Date:	Report completed by:	Agency:	Consent to forward?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 7: Important Medical History – Any Medical Concerns

Note: if completing referral for “Child Specific Contract/Consultation”, complete this section and continue to “SECTION 9”

Name(s): includes specialists, speech language pathologists, mental health team, psychiatrist etc.	Agency & Contact #:	Physical Health Information (Any language, hearing, visual, physical disabilities, allergies, toilet trained, etc.)	Mental Health Information (Any suspected or diagnosis? Any prescribed medication?)

Immunization Record of Child: Yes No Unknown

SECTION 8: Reason(s) For Referral – GENERAL CONTRACTS

Presenting issues - current & specific i.e. requesting program / staff support re: safety concerns, behavioural challenges, social and/or emotional challenges, programming ideas, difficult transitions etc.

1.	
2.	
3.	
4.	

SECTION 9: Support Person Information

Professional support/s. Please indicate if Supported Child Development is involved.

Support Person(s):	a) Role / Relationship b) Length of Involvement	Contact #:	Email:
1.	a) b)		
2.	a) b)		
3.	a) b)		

SECTION 10: Goals of Service Requested – Note goals for child &/or centre

1.	
2.	
3.	

SECTION 11: Consent to Referral for Service

A. FOR CHILD SPECIFIC CONTRACTS & CHILD SPECIFIC CONSULTATIONS:

I / We, the parents/guardians of _____, hereby consent to this referral being made to the PACE Program. To facilitate the intake process, I / We give permission for the PACE Program to discuss with and to request any report or information relevant (from professionals named on this referral form), in assessing PACE as an appropriate service for my child/family.

B. FOR CHILD SPECIFIC CONTRACTS, GENERAL CONTRACTS & CONSULTATIONS:

I/We, the undersigned, having obtained Board / Management approval from _____, hereby apply to the PACE Program to provide support services to our centre.

Parent /Guardian Signature	Printed Name	Date
Parent /Guardian Signature	Printed Name	Date
Centre Supervisor Signature	Printed Name	Date
PACE Child & Family Worker	Printed Name	Date

REFERRAL SCREENING TO BE COMPLETED BY PACE INTAKE TEAM <i>(Executive Director, Team Leader of Outreach Support Services)</i>		Date:
<input type="checkbox"/>	Referral Received	
<input type="checkbox"/>	Intake Team Reviews Referral/Intake Package	
<input type="checkbox"/>	Intake Team Consults with Referral Source(s)	
<input type="checkbox"/>	Intake Team Forwards Intake to Waitlist <i>(if necessary)</i> & Informs Client <i>(parent & or centre)</i>	
<input type="checkbox"/>	Services Declined	
<input type="checkbox"/>	Services Accepted	