Ranch Ehrlo Society Family Centered Addiction Program Referral Form

Does this family meet the FCAP eligibility criteria:

- ☐ Other, less intensive services have been exhausted or are not appropriate.
- ☐ I have described the FCAP to the family members and the parent(s)/caregivers are willing and available to participate.
- ☐ The referred family members do not require medical detoxification
- ☐ All participants agreed to addictions recovery planning
- ☐ The child(ren) can attend a regular childcare &/or educational placement
- ☐ Maintaining the child(ren) in the home is not just a temporary plan. The child(ren) is not on a waiting list or pending entry into group care, psychiatric care, or a juvenile justice institution.
- ☐ Caregivers agree to consistently attend daily programming

Referring Agency Name:	Referring Worker Name:	Referring Worker Phone Number:	
Referring Agency Office Phone:	***EMERGENCY/After Hours*** Phone:	Fax Number:	☐ Child Protection ☐ Justice ☐ Health ☐ Other:
Referent Supervisor:	Supervisor Phone #:	Date of Referral:	
Name of Agency Providing Funding:	Contact Name & Email for Invoicing:	Address for Invoicing: (Nunavut must include the region)	

Family Member Information

Primary Caregivers			
Parent/Caregiver #1 Name:	DOB:	Ethnicity:	Health Card Number:
Parent/Caregiver #2 Name:	DOB:	Ethnicity:	Health Card Number:
Parent/Caregiver Address (including city):		Parent/Caregiver Phone Numbers:	

Child/Youth Identified for Services (or living in home)			
Name:	DOB:	Ethnicity:	Health Card Number:
☐ At Risk of Placement	☐ In Need of Reunification	Currently in home? ☐ Yes ☐ No	If no, current location:
Name:	DOB:	Ethnicity:	Health Card Number:
☐ At Risk of Placement	☐ In Need of Reunification	Currently in home? ☐ Yes ☐ No	If no, current location:
Name:	DOB:	Ethnicity:	Health Card Number:
☐ At Risk of Placement	☐ In Need of Reunification	Currently in home? ☐ Yes ☐ No	If no, current location:
Name:	DOB:	Ethnicity:	Health Card Number:
☐ At Risk of Placement	☐ In Need of Reunification	Currently in home? ☐ Yes ☐ No	If no, current location:
Name:	DOB:	Ethnicity:	Health Card Number:
☐ At Risk of Placement	☐ In Need of Reunification	Currently in home? ☐ Yes ☐ No	If no, current location:
Name:	DOB:	Ethnicity:	Health Card Number:
☐ At Risk of Placement	☐ In Need of Reunification	Currently in home? ☐ Yes ☐ No	If no, current location:
Name:	DOB:	Ethnicity:	Health Card Number:
☐ At Risk of Placement	☐ In Need of Reunification	Currently in home? ☐ Yes ☐ No	If no, current location:

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Below, check the ant areas of risk that are identified for the child(ren) that will be participating in the Family Addictions Program. Check all that apply. If some of the reasons apply to only one or some of the child(ren) and not the other(s), put the child(ren)'s first name(s) in the space indicated.

Child at Risk of Child Abuse / Neglect (check all that apply)

☐ Physical Abuse	☐ Suspected	☐ Confirmed	Victimized Child(ren):	
☐ Sexual Abuse	☐ Suspected	☐ Confirmed	Victimized Child(ren):	
☐ Medical Neglect	☐ Suspected	☐ Confirmed	Victimized Child(ren):	
☐ Emotional Neglect	☐ Suspected	☐ Confirmed	Victimized Child(ren):	
☐ Physical Neglect	☐ Suspected	☐ Confirmed	Victimized Child(ren):	
☐ Supervisory Neglect	☐ Suspected	☐ Confirmed	Victimized Child(ren):	
☐ Environmental Neglect	☐ Suspected	☐ Confirmed	Victimized Child(ren):	

Serious Family Conflict (parent-child conflict only; not domestic violence): ☐ Violent ☐ Non-Violent

Child at Risk of Substantial Harm to Health, Safety and Welfare (check all that apply, identify child when possible)

☐ Behavioral Problems	☐ Developmental disability
☐ Delinquency	☐ Serious mental health issues for the child
☐ Drug or alcohol by the child	☐ Physical handicap or chronic debilitating medical problem
☐ School Problems	☐ Inability of parents to control or manage child's behavior
☐ Inability or decreased ability to protect child from dangerous situations.	☐ Sibling to Sibling Abuse:
☐ Family not engaged in services or not following a child protection service plan	☐ Other:

Caretaker Risk Factors	**Check Your Response** 0 (no risk) to 4 (high risk) (unknown)
Substance Abuse	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Mental, Emotional, Intellectual or Physical Impairments	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Suicide Attempt/Ideation	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Parental Skills/Expectations of Child	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Empathy/Nurturing/Bonding	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
History of Violence or Sexual Assault by Caretakers on Children and/or others	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Protection of Child by Non-abusive Caretaker	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Recognition of Problem/Motivation to Change	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Level of Cooperation	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐
Familial, Social and Economic Factors	
Domestic Violence	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ☐

Others Living in the family setting (relatives, friends, renters etc.)

Name:	DOB:	Attending our program with the family: ☐ yes ☐ no	Relationship / Other Info:
Name:	DOB:	Attending our program with the family: ☐ yes ☐ no	Relationship / Other Info:
Name:	DOB:	Attending our program with the family: ☐ yes ☐ no	Relationship / Other Info:

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Custody Status:

1. Guardian Name:_____ Telephone: _____
2. Guardian Name: _____Telephone: _____

☐ Joint Custody (Please fill out contact information for both guardians)
☐ Sole Custody (Please fill out contact information for the sole guardian)
☐ Lives with both parents/ Married/ Common Law

Medication for each participant

Participant Name	Medication Name	Dose	Frequency
1			
2			
3			
4			
5			

Substance Use (indicate current substances used, amount and frequency). Please detail if there are current or historic symptoms of psychosis.

Please attach a completed risk assessment and/or describe the current events that precipitated this referral, including dates and risk factors for family members. Include a summary of the family members addictions history information and any current symptoms).

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History of child welfare &/or criminal involvement:

Assessment of the Potential for Physical Violence:

Within Family	☐ Very High	☐ High	☐ Moderate	☐ Low	☐ None	☐ Unknown
Towards Others	☐ Very High	☐ High	☐ Moderate	☐ Low	☐ None	☐ Unknown

Comments:

Is Anyone Restricted from Contact?	☐ Yes	☐ No	If yes, who:
Is Anyone Unwilling to Participate?	☐ Yes	☐ No	If yes, who:

Other Safety Concerns/Issues (consider sex offender status, gang involvement, domestic violence, suicide risk, criminal activity etc.):

Supporting Documentation – Completed items to be attached with referral

Medical letter supporting client is healthy to participate in the program	☐ Yes ☐ No
Toxicology screen with 72 hours of admission	☐ Yes ☐ No
Addictions Assessment or summary reports	☐ Yes ☐ No
Assessment and /or child protection case summaries	☐ Yes ☐ No
Psychological Assessments	☐ Yes ☐ No
Educational Reports for all children	☐ Yes ☐ No

Court Hearings / Involvement: ☐ None ☐ Unknown ☐ Yes

If yes, comments:

Family Involved with Following Service Providers		**Provider Name**
Mental Health	☐ **Yes** ☐ **No**	
School	☐ **Yes** ☐ **No**	
Health professionals – list	☐ **Yes** ☐ **No**	
Substance Abuse	☐ **Yes** ☐ **No**	
Other Counseling/Assessment	☐ **Yes** ☐ **No**	
Other Support Services	☐ **Yes** ☐ **No**	

Referent Expectations/Goals for the Family:

1.

2.

3.

4.

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Signatures:

Referent's Signature:_____

Manager's Signature: _____
Ranch Ehrlo Society

Executive Director's
Signature:_____
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