Ranch Ehrlo Society Family Treatment Program Referral Form

Does this family meet the FTP'S eligibility criteria:

- ☐ Services required to meet family needs are not available in the home community; **or**
- ☐ If FTP is not available, one of the following will occur:
  - Child(ren) will be placed/remain in protective custody;
  - Voluntary placement agreement will be initiated;
  - There will be a delay in returning the child(ren) home.
- ☐ Other, less intensive services have been exhausted or are not appropriate.
- ☐ Maintaining the child in the home is not just a temporary plan. The child is not on a waiting list or pending entry into group care, psychiatric care, or a juvenile justice institution.
- ☐ The parent has been informed of the risk of out-of-home placement &/or agrees the intensive need for services.
- ☐ I have described the intensity of the FTP to the family members (daily in home contact), and at least one parent in the home is willing and available to participate.

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 (In home during intervention)			
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:

Is there a referral made to the interprovincial courtesy supervision desk, Child Protection or Youth Justice? ☐ Yes ☐ No ** If Yes – name and phone number of courtesy worker:	Courtesy Worker: Phone Number:

Below, check the reasons the child(ren) identified for services are identified as AT RISK OF PLACEMENT; or IN NEED OF REUNIFICATION or the REASON FOR REFERRAL. Please 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 or cognitive challenges
☐ 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 MSS service plan	☐ Other:

Current Placement Issues

☐ Child is currently out of the home, and the family needs assistance with transition home	
☐ Child requesting placement	☐ Parent/Caregiver requesting placement
☐ Child is a run away/ refusing to return home	☐ 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☐	☐
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 Home (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:

Reason for Referral (attach the completed risk assessment and/or describe the current events that precipitated this referral, including dates and risk factors)

History of Child Welfare involvement (if applicable):

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			
Safety Assessment & Family Assessment	☐ Yes	☐ No	
Reunification Plan Completed	☐ Yes	☐ No	
Copy of School Report cards	☐ Yes	☐ No	**If outside of Regina**
Copy of Educational Assessments	☐ Yes	☐ No	
Parental Consent to Share Education Info	☐ Yes	☐ No	
Parent/Child Assessments	☐ Yes	☐ No	**List:**
Copy of current legal authority	☐ Yes	☐ No	
Copy of most recent client progress review	☐ Yes	☐ No	
Probation/Undertakings	☐ Yes	☐ No	
Discuss concerns of present alcohol/drug abuse	☐ Yes	☐ No	

Court Hearings / Involvement: ☐ None ☐ Unknown ☐ Yes	
If yes, comments:	

Family Involved with Following Service Providers		**Provider Name: (or if "No'", is this an issue/service request?)**
Day Care	☐**Yes** ☐ **No**	
School	☐**Yes** ☐**No**	
Health/ Mental Health	☐ **Yes** ☐**No**	
Public Health Nurse	☐ **Yes** ☐**No**	
Substance Abuse	☐**Yes** ☐**No**	
Other Counseling/Assessment	☐**Yes** ☐**No**	
Other Support Services	☐**Yes** ☐**No**	
Elder services	☐**Yes** ☐**No**	

Is housing required?	☐**Yes** ☐ **No**	**Please forward Family Support Services Contract or Applicable Funding Confirmation**
Is funding confirmed?	☐**Yes** ☐ **No**	
Duration of Treatment Recommended:		
Anticipated Commencement of Treatment:		

Referent Expectations:

1.

2.

3.

4.

Referent's Signature:_____

Agency Supervisor Signature:_____
(Supervisor's authorization is required)

Executive Director of Family Treatment Programs Signature:
_____

Please send to: Patti Petrucka MSW, RSW
Ranch Ehrlo Society
Executive Director of Family Treatment Programs
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Ph: (306)751-2913 Fax: (306) 751-2909