Vancouver Family Preservation & Reunification Services
CRISIS SERVICE REFERRAL FORM [TWO-WEEK SERVICE]

SOUTH REFERRALS:
Tel: 604-875-6277
Fax: 604-875-0760

NORTH REFERRALS:
Tel: 604-254-5457
Fax: 604-254-6169

*NOTE: Please complete all sections marked with an asterisk * If information request is 'unknown', please specify.*

Director of Operations Approval (Name): _____

Approval Signature: _____ Date: _____

DATE OF REFERRAL _____

MCFD OFFICE CODE _____ ☐ NORTH ☐ SOUTH

SOCIAL WORKER: _____ OFFICE: _____ CELL: _____

FAMILY COUNSELLOR:(IF APPLICABLE) _____ CELL: _____

Client Last Name: _____ First Name: _____

D.O.B. mm/dd/yy _____ Male ☐ Female ☐

Phone: (C) _____

Address: _____

Crisis Service Referrals: Defined as a two-week Service(s) that prevent(s) Child(ren) from being required to come into Out-Of-Home Placement. Maximum Service hours are to be no more than 35 hours over two weeks, with maximum 3 hrs/day. Please note that a Family Preservation Services Referral must be made in conjunction with this referral if there is not currently Family Preservation involvement.

SERVICE PRIORITIES / NEEDS / GOALS: (Please attach Family/Safety Plan when possible, and be specific with Service description and structure/design, for example, Time of Day, Day(s) of the Week, and so forth).

*__General Themes & Presenting Issues:__

*__Language preference:__ _____ *__Culture__: _____ *__Indigenous?__ Yes ☐ No ☐

*__Are there any circumstances that may pose a risk to service providers?__ Yes ☐ No ☐ Possible concerns ☐

If yes and/or possible concerns, please comment:

*__Have risks for suicide been identified for any family members?__ Yes ☐ No ☐ Possible Concern ☐

If yes and/or possible concerns, please comment:

OTHER ADULT FAMILY MEMBERS: (Please provide information if applicable)

NAME:				**Relationship:**	
M ☐	**F ☐**	**D.O.B.: (mm/dd/yy)**		**Phone: (H)**	
Address:				**Phone: (C)**	
NAME:				**Relationship:**	
M ☐	**F ☐**	**D.O.B.: (mm/dd/yy)**		**Phone: (H)**	
Address:				**Phone: (C)**	

CHILDREN: (Please provide information where applicable)

NAME:						**Relationship:**	
M ☐	**F ☐**	**D.O.B.: (mm/dd/yy)**		**AGE:**		**Legal Status/ Custody:**	
		Whereabouts:				**Expiry Date:**	
Address:						**Foster Parent Name:**	
School/ Daycare:						**Contact: Contact Phone:**	
NAME:						**Relationship:**	
M ☐	**F ☐**	**D.O.B.: (mm/dd/yy)**		**AGE:**		**Legal Status/ Custody:**	
		Whereabouts:				**Expiry Date:**	
Address:						**Foster Parent Name:**	
School/ Daycare:						**Contact: Contact Phone:**	

ANY ADDITIONAL INFORMATION: (Please provide further information if YES and/or Possible Concerns is checked below)

Is the use of **drug, alcohol, or other addictions** identified as an issue (inclusive of risk-taking behaviours)?
Yes ☐ No ☐ Possible Concern ☐ _____

Are there **anger/violence/domestic** (intimate partner) issues?
Yes ☐ No ☐ Possible Concern ☐ _____

Are there **criminal activity concerns** and/or criminal investigations currently pending?
Yes ☐ No ☐ Possible Concern ☐ _____

Are there **mental health issues**?
Yes ☐ No ☐ Possible Concern ☐ _____

Has this family or any of its members been **impacted by trauma**?
Yes ☐ No ☐ Possible Concern ☐ _____

Are any members of this family being **treated for any medical conditions** (Please provide details if available)?
Yes ☐ No ☐ Possible Concern ☐ _____

Do any members have **allergies or adverse reaction to medication(s)**?
Yes ☐ No ☐ Possible Concern ☐ _____

Do any family members have **disabilities/special equipment requirements**?
Yes ☐ No ☐ Possible Concern ☐ _____

Any additional Information if Yes and/or Possible Concerns checked for items above: