Family Services of Greater Vancouver

WFC Westcoast Family Centres — BUILDING BLOCKS FOR BETTER LIVES

VANCOUVER FAMILY PRESERVATION & REUNIFICATION SERVICES
PRIMARY ASSESSMENT / REFERRAL FORM
AUGUST 2021

Purpose: The following assessment/referral form must be completed by referring agency and submitted to the respective referral agency (South/North). Please note: Supervised Access Services requires a different form.

SERVICE(S) REQUESTED:					
Family Counsellor ☐	PRIYD ☐	Clinical Counselling ☐	FC/FLA* ☐ FC(CP)/ FLA** ☐	Doula ☐	Resource ☐

South Referrals - Family Services of Greater Vancouver:
Tel: 604-875-6277 | Fax: 604-875-0760

North Referrals - Westcoast Family Centres:
Tel: 604-254-5457 | Fax: 604-254-6169

WFC Admin Use Only:	Date Fax Rec'd:	Staff Assigned:

Note: Family Law Act (FLA) Involvement with this Case. ** Family Law Act (FLA) Involvement with this Case & Child Protection Concerns.*

Referral Date:	Referring S.W.:		MCFD Office:
	S.W. Phone:		S.W. Fax:
Client Last Name:	First Name:		Phone: (H)
D.O.B. mm/dd/yy	Male ☐	Female ☐	Phone: (C)
Address:			Postal Code:

Re-Referral:	Yes ☐	No ☐	CCO:	Yes ☐	No ☐

Length of Service:
- 8 – 12 weeks ☐
- Protection mandated ☐
- Voluntary/Support ☐
- 6 months ☐
- Protection mandated ☐

General Information:

*Number of MCFD investigations: _____
*Number of out of home placements: _____ *Length of time in care: _____
*Child protection court date: _____ *Type of hearing: _____
*Number of out of home placements: _____ *Length of time in care: _____
*Supervision order? Yes ☐ No ☐ *Date of expiry: _____

*General themes:

*Language preference: _____ *Culture: _____ *Indigenous? Yes ☐ No ☐
Worker preference: Male ☐ Female ☐ Other diversity considerations: _____
*Days ☐ Evenings ☐ Weekends ☐

*Is the family receptive to this service? Yes ☐ No ☐

If no, please comment:

*Are there any circumstances that may pose a risk to service providers? Yes ☐ No ☐

If yes, please comment:

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

If yes, please comment:

OTHER ADULT FAMILY MEMBERS:

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: (Use Additional space on last page as required)

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:	
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:	

Please complete as much information as possible. See Page 5 for Foster Parent information

OTHER ADULT FAMILY MEMBERS (Continued from previous page)

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:

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:	
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:	

BACKGROUND INFORMATION:

*How did this family come to the attention of MCFD? *If this Case has Family Law Act (FLA) involvement, please describe the status of the involvement, if possible.*

*Please identify child protection concerns:

*Please identify who will be involved in service:

Please comment on family functioning (including personal strengths, individualized needs/abilities/interests):

Issues important to and preferences of family:

FAMILY HISTORY:

*Is the use of drugs, alcohol or other addictions identified as an issue (inclusive of any other risk-taking behaviours)?

Yes ☐ No ☐ Possible Concern ☐ Not Assessed ☐

If yes or possible concern, type of addiction(s), how has this been addressed, current supports?

*Are there anger/violence issues?

Yes ☐ No ☐ Possible Concern ☐ Not Assessed ☐

If yes or possible concern, how have these been addressed, current supports?

*Is there a Restraining Order?

Yes ☐ No ☐

If yes, provide details:

*Is criminal activity a concern?

Yes ☐ No ☐ Possible Concern ☐ Not Assessed ☐

If yes or possible concern, provide details:

*Are there mental health issues?

Yes ☐ No ☐ Possible Concern ☐ Not Assessed ☐

If yes or possible concern, how has this been addressed, current supports?

Educational/Literacy Level:

Employment History:

*Has this family been impacted by trauma or abuse?

Yes ☐ No ☐ Possible Concern ☐ Not Assessed ☐

If yes or possible concern, how has this been addressed, current supports?

Has this family been impacted by refugee or immigration experience?

Yes ☐ No ☐

If yes, please comment:

HISTORY OF SUPPORTS AND SERVICES:

Past supports/services/ supportive relationships for parent(s):

Current supports/services/supportive relationships for parent(s):

Past supports/services/supportive relationships for child(ren):

Current supports/services/supportive relationships for child(ren):

Comment on any issues related to children's speech, hearing, and visual functioning. Also comment on issues related to pre-natal exposure to alcohol or other drugs:

MEDICAL HISTORY/PERSONAL FUNCTIONING:

Are any family members being treated for any medical conditions? Please give details (including medication use profile and efficacy of current or previously used medication):

Do any family members have allergies or adverse reactions to medication?

Yes ☐ No ☐ Unknown ☐

Please give details:

Do any family members have disabilities/special equipment required?

Yes ☐ No ☐ Unknown ☐

Please give details:

*SERVICE PRIORITIES / NEEDS / GOALS: Please attach Family Plan when possible

*FOSTER PARENT INFORMATION			*FOSTER PARENT INFORMATION		
Confidential:	Yes ☐	No ☐	Confidential:	Yes ☐	No ☐
Child's Name:			Child's Name:		
Foster Parent(s):			Foster Parent(s):		
Address:			Address:		
Phone: (H)	Phone: (C)		Phone: (H)	Phone: (C)	
How often does the parent visit the children?			How often does the parent visit the children?		
Are the visits with the child/ren supervised?			Are the visits with the child/ren supervised?		
	Yes ☐	No ☐		Yes ☐	No ☐