CARING DADS REFERRAL FORM

Print Form

☐ Self Referral ☐ Agency Referral

Please submit via fax 905-546-5779 or call 905-527-3823, Ext. 279, to complete over the phone

Name:	Date of Birth	Address:
Phone: Cell: Work: Home:	Safe to leave voicemail? ☐ Yes ☐ No	City: Postal Code:

Are there any concerns with reading or writing English? ☐ Yes ☐ No

Is an interpreter required: ☐ Yes ☐ No Language:

Are there issues with addiction? ☐ Yes ☐ No

Is there a personal history of abuse-related trauma? ☐ Yes ☐ No

Are there any medical / mental health issues we should be aware of? ☐ Yes ☐ No

Risk of suicide? ☐ Low ☐ Medium ☐ High

Are there limitations on contact with (ex) partner and/or child(ren)? i.e., C/CAS stipulation, bail condition, peace bond, probation order, restraining order? ☐ Yes ☐ No

Are there charges before the courts? ☐ Yes ☐ No

Has there been/is there a risk for using abuse or controlling behaviour against your partner or child? ☐ Partner ☐ Child ☐ Child witnessed

Please expand in additional information section

Are there any barriers to group participation?

MOTHER CONTACT INFORMATION

Please provide contact information for the mothers affiliated with this referral. It may be biological mothers, or women whose children you (the client) has been parenting. If there are more than two, please copy this page.

	☐ Mother of biological children ☐ Mother of children client is parenting	☐ Mother of biological children ☐ Mother of children client is parenting
Name		
Date of Birth		
Address		
Telephone	Safe to leave message: ☐ Yes ☐ No	Safe to leave message: ☐ Yes ☐ No
Relationship status	Choose one from list:	Choose one from list:
Contact	☐ phone only ☐ in person ☐ none ☐ no contact, but visits with children	☐ phone only ☐ in person ☐ none ☐ no contact, but visits with children

CHILD INFORMATION

	Child's Name	M / F	DOB	Parents	Residence	Custodial Status
1		☐ M ☐ F				
2		☐ M ☐ F				
3		☐ M ☐ F				
4		☐ M ☐ F				
5		☐ M ☐ F				
6		☐ M ☐ F				

How often is there contact with the children if they do not reside with you (the client)?

Are visits: ☐ Supervised By who:

☐ Unsupervised

ADDITIONAL INFORMATION

Please include any pertinent information regarding custody / access, historical / pending charges, risk level, trauma, violence within the family, etc. Attach additional pages if required.	
Please comment on the nature and extent of use of (or risk for) abusive behaviour.	
For self-referrals: please comment on what you hope to gain from participating in group.	

Referring Worker:	Agency:	Phone:

FOR CFS USE ONLY:

Screening Appointment:	Outcome:
Mother Contacted: ☐ Yes ☐ No	Date:

March 2017