



Referral for Services – Section 1*

Supporting Healthy Transitions Program

Forward completed “Section 1” of referral to the PACE Program:

Fax: 604-266-3041 Email: admin@thepaceprogram.ca Attention: Intake Team

- NOTE:** 1) * If determined to be a suitable application, “Section 2” of the referral form will be forwarded for completion.
 2) ** If siblings live in separate homes & are both transitioning, please fill in separate referral for each foster home.

1 A: Referral Information

Referred By:		Role/Position:	
Referral Date:		Contact #:	Fax#:
Length of time involved with child/family:		Email Address:	
Current Foster Home / Parent Names :		Phone #:	
Social Worker:		Phone #:	
Resource Social Worker:		Phone #:	

1 B: Transitioning Child/ren (from foster home noted above)

Child’s Legal Name:		Date of Birth:	
Child’s Legal Name:		Date of Birth:	
Child’s Legal Name:		Date of Birth:	

1 C: Transitioning Child/ren (if living in another home) - PLEASE SEE NOTE 2) above**

Child’s Legal Name:		Date of Birth:	
Child’s Legal Name:		Date of Birth:	
Child’s Legal Name:		Date of Birth:	

1 D: Reason for Referral / Transition Plan

Transition Date:

Consent to Referral for Service

- ❖ I, _____, the legal guardian of the above named children in the foster home of _____, request support from the “Supporting Healthy Transitions Program” to the foster home (“primary” home), the “transition” home (either foster, birth or adoptive home) and the children involved/impacted by this transition in each of the homes.
- ❖ To facilitate the intake process, I give permission for the PACE Program to discuss with and to request any report or information relevant (from professionals named on this referral form), in assessing PACE as an appropriate service.
- ❖ ***I understand this form is the first section of a two part referral form, which will be completed if referral is deemed suitable for the program.***

Legal Guardian Signature

Printed Name

Relationship to Child