The PACE Program
Website: www.thepaceprogram.ca

Referral for Services – Outreach Support Services

Forward completed referral to the PACE Program:
Fax: 604-266-3041 Email: admin@thepaceprogram.ca Attention: Intake Team

TYPE OF SUPPORT REQUESTED:

- ☐ **General Contract** *(complete sections 1, and 8 through 11 only)*
- ☐ **Child Specific Contract** *(complete sections 1 through 8, and 10 through 11)*
- ☐ **Short Term Consultation** - 1 or 2 visits *(complete sections as noted above)*

SECTION 1: Referral Information – CENTRE

CENTRE / PROGRAM INFORMATION:

Program Name:			
Address:			
Phone:	Fax:	Email:	
Supervisor:			
Primary Contact:			
Staff names:			

Network:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

Licensing Consultant:				Phone:	
Inclusion Contract:	☐ Yes ☐ No	For How Many Children?		Parent Involvement in Centre?	☐ Yes ☐ No

PREFERRED DAY & TIME FOR SUPPORT:

DAY PLEASE NOTE: we will try to accommodate your preference, however due to the demand for service, it may not be possible.	**PREFERRED TIME** (a.m. / p.m.)
1. ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	
2. ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	
3. ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	

Hours of Operation:		Holidays/Closures? *Please specify:*	
Staff Meeting Times:			

ABOUT THE CHILDREN IN CENTRE:

Total number of children in centre:		Number of those full time:		Number of those part time	
Total number of children ESL:		Languages spoken:			
Predominant Cultures of Children in Centre (and number in group, if known)					
☐	Aboriginal band/s :	☐	Please list:		

ABOUT THE STAFF:

☐	Aboriginal band/s :	☐	Please list:
Languages spoken:			

SECTION 2: Referral Information – CHILD SPECIFIC CONTRACTS

If completing referral for General Contract/Consultation, please go to **"SECTION 8"**.

Child's Legal Name:		Date of Birth:	
Child Known As:		Gender:	

Address:					
Primary Caregiver:		Relationship to child:			
Primary Caregiver:		Relationship to child:			
Language(s) Spoken:		Emergency Contact #:			
Home #:		Work #:		Cell #:	
Email:					

Others in the home?	Sibling?	Gender	Age	Date of Birth
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

Household Composition:

☐	Single Parent	☐	Couple	☐	Co-Parenting	☐	Extended Family

Ethnicity of Child:

☐	Please define:	

Ethnicity of Parent:

☐	Please define:		
If immigrant, where from?		Describe any cultural factors that may affect service delivery:	

Custodial Status of Child Referred *– if birth parent/s not primary caregiver or legal guardian:*

Legal Guardian:		Child's Legal Status:	
Expiry of Legal Status:		Date of Next Review / Court:	
Parent Contact with Child? ☐ Yes ☐ No		Frequency:	Restrictions? ☐ Yes ☐ No

SECTION 3: Reason(s) For Referral – CHILD SPECIFIC CONTRACTS

Presenting issues/risk factors, current & specific information
*(*i.e. safety concerns, behavioural challenges, social and/or emotional challenges, changes in family, mental health issues, cognitive issues, multiple issues, placement breakdown, impending changes / recent events etc.)

1.	
2.	
3.	
4.	

SECTION 4: Child & Family History - *Please indicate any key issues such as moves, separations, loss, apprehensions, trauma (and indicate dates, where possible.)*

1.	
2.	
3.	
4.	

SECTION 5: Child's Strengths, Needs, Concerns - *Please list*

Please list strengths and skills regarding the child:	***List specific emotional and/or behavioural issues re: child*** *(e.g. anxiety, aggression) and known events/factors*	***Please list any other needs/concerns regarding child at this time:***

SECTION 6: Previous Child Care Program(s)

Program:	From When to When:	Contact Person and Phone #:

SECTION 7: Therapy & Important Medical History – *Including any medical concerns*

Name(s): Please include specialists, speech language pathologists, mental health team, occupational therapist, physiotherapist, psychiatrist etc.	Agency:	Contact #:

Are there any reports being forwarded – please list	☐ Yes	☐ No	☐ Unknown

Date:	Report completed by:	Role:	Consent received to forward?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Physical Health Information Any issues re: language, hearing, visual, physical development; Any allergies, toilet training issues, etc.	**Mental Health Information** Any suspected or any diagnosis? Any prescribed medication?
Immunization Record of Child on file?	☐ Yes ☐ No ☐ Unknown

SECTION 8: Support People Involved in Centre - *Professional support/s*

Please indicate if Supported Child Development is involved

Support Person(s):	a) Role / Relationship b) Length of Involvement	Contact #:	Email:
1.	a) b)		
2.	a) b)		
3.	a) b)		

SECTION 9: Reason(s) For Referral – GENERAL CONTRACTS

Presenting issues - current & specific i.e. requesting program / staff support re: safety concerns, behavioural challenges, social and/or emotional challenges, programming ideas, difficult transitions etc.

1.	
2.	
3.	
4.	

SECTION 10: Goals of Service Requested - Please note goals for child &/or centre below	
1.	
2.	
3.	

SECTION 11: Consent to Referral for Service

A. FOR ALL CONTRACTS:

NOTE: *Approval from the Board/Management is required prior to being placed on waitlist for service*. Please complete section below prior to sending referral into to PACE.

Type of Board / Management: e.g. parent-run, private		
Contact Name:		
Phone:	Fax:	Email:
Approval to apply to PACE for service was received from:		
Centre Supervisor Signature:		

B. FOR CHILD SPECIFIC CONTRACTS & CHILD SPECIFIC CONSULTATIONS:

I / We, the parents/guardians of _____ , hereby consent to this referral being made to the PACE Program. To facilitate the intake process, I / We 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 for my child/family.

_____	_____	_____
Parent /Guardian Signature	Printed Name	Date
_____	_____	_____
Parent /Guardian Signature	Printed Name	Date
_____	_____	_____
Centre Supervisor Signature	Printed Name	Date

REFERRAL SCREENING TO BE COMPLETED BY PACE INTAKE TEAM *(Executive Director, Team Leader of Outreach Support Services)*		Date:
☐	Referral Received	
☐	Intake Team Reviews Referral/Intake Package	
☐	Intake Team Consults with Referral Source(s)	
☐	Intake Team Forwards Intake to Waitlist (if necessary) & Informs Client (parent & or centre)	
☐	Services Declined	
☐	Services Accepted	