The PACE Program

Working together to foster emotional well-being in our community through connection, support and education

The PACE Program
1524 West 65th Avenue, Vancouver BC V6P 2R1
phone: (604) 266-3141 fax: (604) 266-3041
email: admin@thepaceprogram.ca
www.thepaceprogram.ca

Supporting Healthy Transitions Program

REFERRAL FOR SERVICES *

Forward completed referral to the Intake Team at the PACE Program by:

Fax: 604-266-3041 or **Email: admin@thepaceprogram.ca**

NOTE: * If siblings live in separate homes & are also transitioning, please fill in separate referral for each foster home.
If additional space in any area is needed, please attach a separate sheet noting section.

A. Referral Information:

Referred By:			Referral Date:		
Role:			Office Code:		
Office #		Direct Line #		Cell #	
Length of time involved with child/family:			Email:		
ESTIMATED TRANSITON DATE:					

Reason for Referral:

B. Transitioning Child/ren (In foster home noted in section E):

Child's Legal Name:		Date of Birth:	
Gender:		Pronouns:	
Ethnicity / Cultural Factors:		Nation *(if applicable)*:	
Child's Legal Name:		Date of Birth:	
Gender:		Pronouns:	
Ethnicity / Cultural Factors:		Nation *(if applicable)*:	
Child's Legal Name:		Date of Birth:	
Gender:		Pronouns:	
Ethnicity / Cultural Factors:		Nation *(if applicable)*:	

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C. Transitioning Child/ren Living in Another Home (Please complete separate referral):

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

D. Custodial Status of Child/ren Referred:

Legal Guardian Name:		Child/ren's Legal Status:	
☐ MCFD ☐ MFS ☐ VACFSS ☐ AMM			
Expiry of Legal Status:		Date of Next Review / Court:	
Any birth parent/s contact with child/ren? ☐ Yes ☐ No	Who & frequency:		
Restrictions? ☐ Yes ☐ No			
Is birth parent/s aware of referral	☐ Yes ☐ No	Are they in agreement with this referral?	☐ Yes ☐ No

E. Current Home of Child/ren Transitioning (PRE HOME):

Type of Home: *i.e. foster home, relatives/extended family, others*					
Address:					
Primary Caregiver #1:				Relationship to child:	
Date of Birth / Age:				Language(s) Spoken:	
Ethnicity:				Cultural Factors:	
Home #:		Work #:		Cell #:	
Email:					
Primary Caregiver #2:				Relationship to child:	
Date of Birth / Age:				Language(s) Spoken:	
Ethnicity:				Cultural Factors:	
Home #:		Work #:		Cell #:	
Email:					

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F. Future Home of Child/ren Transitioning (POST HOME) – if known at time of referral:

Type of Home: *i.e. adoptive home, birth home, foster home, relatives/extended family, others*					
Address:					
Primary Caregiver #1:			Relationship to child:		
Date of Birth / Age:			Language(s) Spoken:		
Ethnicity:			Cultural Factors:		
Home #:		Work #:		Cell #:	
Email:					
Primary Caregiver #2:			Relationship to child:		
Date of Birth / Age:			Language(s) Spoken:		
Ethnicity:			Cultural Factors:		
Home #:		Work #:		Cell #:	
Email:					

G. Consent to photograph for creation of memory books:

- As the legal guardian of the child/ren named in this referral, I give consent to share photographs and/or for the child/ren being photographed so the PACE Family Counsellor can create memory books and/or materials to support the child/ren transitioning.

YES	☐	**NO**	☐

Comments:

H. Consent to Share Information with those applicable / noted below:

- In addition to the "*Current Home" (PRE HOME) and "Future Home" (POST HOME) - section B & E*, consent is given to the PACE Program staff to discuss with the following people/agencies any information relevant to providing the best support and service for the child/ren named in this referral, and to obtain any written reports, if applicable.

- **These are required,** complete as applicable**:**

Role:	Office Code:	Name:	Agency / Relationship:	Direct #:	Office #:	Email:
Resource Social Worker						
Adoption Social Worker						
Child's Pre-Transition Social Worker						
Child's Post-Transition Social Worker						
Family Service Social Worker						

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- **Please add people below,** as applicable**:**

Role:	Name:	Agency / Relationship:	Direct #:	Office #:	Email:
Birth / Extended Family (Involved and *not where child/ren reside or are moving to)*					
Child & Youth Mental Health Clinician					
Pediatrician					
Psychiatrist					
Daycare / Preschool / School / Support Staff					
Infant Development Program					
Fostering Early Development					
Roots Worker					
Cultural Connection					
Counsellor					

I. Consent to Referral for Service:

Consent includes reviewing each of the following items and signing below:

- As the legal guardian of the above-named child/ren, I request support from the *"Supporting Healthy Transitions Program*" to the current home (PRE HOME), the home the child/ren are moving to (POST HOME – whether a foster, birth or adoptive home) and the child/ren involved/impacted by this transition in each of the homes, as applicable.
- I confirm that both the "PRE HOME" and the "POST HOME" as well as the other supports currently involved with these homes are aware of, and in agreement with, this referral, where possible.
- I understand that upon the end of service or participation, a "*Closing Report*" will be completed and forwarded to the following, as appropriate:
    - Referral Source and/or the child's Social Worker,
    - Resource Social Worker, if applicable
- I understand that the consent to share information and consent for service includes the intake process as well as the service delivery process. I understand that this consent expires after one year from date of this referral and can be renewed again, on a separate document, if applicable*.

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COMMENTS / NOTES:

Legal Guardian Name:	
Legal Guardian Signature:	
Relationship to Child:	

COMPLETED BY PACE INTAKE TEAM – REFERRAL PROCESS DATES:	DATE:
Referral for Service received, *including being signed*	
Waitlist Date	
Intake Date	
Service Start Date	
Services Declined / No Longer Applicable – *please circle*	
* CONSENT EXPIRY DATE - maximum 1 year from date on referral	