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

Outreach Support Services

REFERRAL FOR 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 / PROGRAM

Program Name:					
Address:					
Phone:		Email:			
Supervisor:					
Primary Contact:					
Staff names:					
Licensing Consultant: *(required)*			Phone:		
Inclusion Contract:	☐ Yes ☐ No	# of Children?		Parent Involvement in Centre?	☐ Yes ☐ No

PREFERRED DAY & TIME FOR SUPPORT:

PLEASE NOTE: we will try to accommodate your preference, however due to the demand for service, it may not be possible.

DAY	**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 full time:		Number of part time:		Total number of ESL:	

Predominant Cultures of the Children:

☐ Indigenous - *nation:* ☐ Hispanic ☐ Asian ☐ South Asian ☐ Caucasian ☐ Other - *please list:*

Languages Spoken:	

Predominant Cultures of the Staff:

☐ Indigenous - *nation:* ☐ Hispanic ☐ Asian ☐ South Asian ☐ Caucasian ☐ Other - *please list:*

Languages Spoken:	

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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:		Pronouns:	
Gender:	☐ Male ☐ Female ☐ Transgender/Gender Diverse ☐ Don't Wish to Share		
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:	Age:
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Household Composition:

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

Ethnicity of Child:

☐ Indigenous - *nation:* ☐ Hispanic ☐ Asian ☐ South Asian ☐ Caucasian ☐ Other - *please list:*

Ethnicity of Parent(s):

☐ Indigenous - *nation:* ☐ Hispanic ☐ Asian ☐ South Asian ☐ Caucasian ☐ Other - *please list:*

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.	

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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 the 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 #:

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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: Professional Support People Involved in *Centre*

Please indicate if Supported Child Development or Richmond Supported Child Development (ASPIRE) are 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.	

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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			
Name of Owner/Director:		**Approval for PACE Services Received by Owner/Director:**	☐ Yes ☐ No
Phone:		Email:	
Name of Centre Supervisor:			
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