Camrose Association for Community Living

Healthy Families

Date: yyyy-mm-dd

Referral For:

Mother's Name: Date of birth: yyyy-mm-dd

Address: City:

Postal Code: Phone Number: Alternate Phone:

Is Father the Primary Referral for the Program?
If Yes Complete the following Section Yes ☐ No ☐

Father's Name: Date of birth: yyyy-mm-dd

Address: City:

Postal Code: Phone Number: Alternate Phone:

Referral Source: Name: Organization: Contact #:

Family is Aware of and Has Agreed To Be Contacted By a Healthy Families Facilitator? Yes ☐ No ☐

Reasons for Referral (This family could benefit from help or support regarding):

- ☐ Pregnancy
- ☐ Parenting Infants/ Children 0-3 (Parental Support)
- ☐ Knowledge of Parenting and Child Development
- ☐ Current Substance use in the Home/ Family
- ☐ Ability to Access Supports in Times of Need
- ☐ In the Past Have Delivered a Child with FASD or Suspected
- ☐ Healthy Social and Emotional Development of Children
- ☐ Adequate Social Connections Available for Parent (i.e.. Social Isolation Concerns)

- ☐ Parenting Attitudes or Behaviours
- ☐ Late or No Prenatal Care
- ☐ Current or History of Family Violence
- ☐ Parental Resilience/ Ability to Cope With and Recover from Challenges
- ☐ Mother Under Age 18 or Over 35
- ☐ Lack of Basic Necessities (Food, Housing)
- ☐ Current or Past Involvement With Child Intervention
- ☐ Baby Care
- ☐ Current Depression or Emotional Health Concerns

☐ Other (Please Specify):

Prenatal Referral:

Expected Delivery Date: yyyy-mm-dd Doctor / Pediatrician Name:

Gestation (# of Weeks): Clinic Attending:

Postnatal Referral (0-3 Years of Age):

Child's Name: _____ Date of Birth: yyyy-mm-dd Age:

_____ Date of Birth: yyyy-mm-dd Age:

_____ Date of Birth: yyyy-mm-dd Age:

_____ Date of Birth: yyyy-mm-dd Age:

_____ Date of Birth: yyyy-mm-dd Age:

Connected to Other Services: _____

_____

_____

Additional Information:

Office Use Only

Intake Worker: First Contacted Date:

Home Visit Booked: yyyy-mm-dd Mentor Assigned:

Updated Referral Source? Yes ☐ No ☐

Dates and Times of Attempted Contact:

Does Not Meet Criteria Referred To:

Referral Status: Accepted ☐ Declined ☐ Unable to Contact ☐ Moved ☐ Refused ☐

Notified Referral Source: ☐

Provide Referral to Appropriate Site

City & County of Camrose
Fax: 780-672-7484 Phone: 780-672-0257
camrosereferral@cafcl.org

Town & MD of Provost
Fax: 780-753-2788 Phone: 780-753-2289
provostreferral@cafcl.org

Beaver County (Tofield)
Fax: 780-662-3854 Phone: 780-662-7067
beaverreferral@cafcl.org

Flagstaff County
Fax: 780-385-3667 Phone: 780-385-3976 Cell: 780-385-8501
flagstaffreferral@cafcl.org

Town & MD of Wainwright
Fax: 780-842-5783 Phone: 780-842-5481
wainwrightreferral@cafcl.org

Bashaw and Area
Phone: 780-372-4074 Cell: 780-679-8066
alyle@cafcl.org