Ranch Ehrlo Society
Treatment Foster Care Program
referral information

Does this referral meet the TFCP criteria?

- ☐ The child requires specialized treatment within a family environment.
- ☐ The child can be cared for safely in a treatment foster family residing in the community:
    - Child does not exhibit at-risk behaviours requiring 24/7 intensive supervision, support and care.
    - Child does not exhibit aggressive behaviours that pose a significant threat to welfare of other children or adults.
    - Child does not exhibit severe physical, mental, or developmental issues requiring an alternative treatment resource.
- ☐ The child has a viable family reunification plan achievable within 24 months.
    - The child is agreeable to family reunification.
    - The parents, extended family members, or caregiver identified for reunification are agreeable to the family reunification plan.
- ☐ The parents or caregivers identified for reunification are willing to participate in the pre-intake and intake meetings and to work with the treatment foster care parents and program.

PRIMARY REFERRAL

Child's Name: ____

Date of Birth: _________________ Birth Place: ____________________

Health Number: _________________ Treaty Number: ____________________

Status (ie: Ward; Parental Agreement) Please attach copy: ___________________________

Current Placement: ______________________ Length of Stay: ____________________

Is English the child's first language: ☐ Yes ☐ No

If not, what language is spoken at home? _______________________________

Please provide a physical description of the child (ie: height, weight, scars/tattoos, hair and eye color):

____

____

____

REFERENT INFORMATION

Referent Name: ____ Referral Date: ________________________

Phone: __________________________________ E-mail:____

Address:____

MSS Supervisor: _____________ Supervisor Phone: ___________________

Funding Information

Treatment Foster Care Invoices to: ____

Is placement at Ranch Ehrlo School requested? ☐ Yes ☐ No

If yes, education invoices to: ☐ ICFS Agency ☐ Province of Saskatchewan

Other: ____

FAMILY/CAREGIVERS IDENTIFIED FOR REUNIFICATION

Name of Mother/Maternal Caregiver: ___________________________ Date of Birth: ______________________

Include Maiden Name if different from above: ____

Address: ____Phone Number: ____________

Occupation/Employer: ____

Describe the relationship with their child and their interest in reunification:

____

____

____

Name of Father/Paternal Caregiver: ___________________________ Date of Birth: ______________________

Address: ____Phone Number: ____________

Occupation/Employer: ____

Describe the relationship with their child and interest in reunification:

____

____

____

Siblings/Significant Others

Name	Relationship	Location	Contact (Y/N)

Caregiver Risk Factors (Check your response)

	0 (no risk) to 4 (high risk)	9 (unknown)
Substance Abuse	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Mental, Emotional, Intellectual or Physical Impairments	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Parental Skills/Expectations of Child	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Empathy/Nurturing/Bonding	0☐ 1☐ 2☐ 3☐ 4☐	☐9
History of Violence or Sexual Assault	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Protection of Child by Non-abusive Caretaker	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Recognition of Problem/Motivation to Change	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Level of Cooperation	0☐ 1☐ 2☐ 3☐ 4☐	☐9

Familial, Social and Economic Factors

Environmental Conditions	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Stress on Family	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Social Support for Family	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Economic Resources of Family	0☐ 1☐ 2☐ 3☐ 4☐	☐9
Domestic Violence	0☐ 1☐ 2☐ 3☐ 4☐	☐9

Have other family members been explored as a potential placement?

____

____

Additional Information Family (strengths, challenges or information not already documented)

____

____

____

MEDICAL HISTORY:

Please include a copy of the Immunization Records.

Medical Issues:

☐ Allergies ☐ Asthma ☐ Dental Problems ☐ Disabilities ☐ Seizures

☐ Immunizations ☐ Diabetes ☐ Bleeding/Bruising

If any of the above are checked, please describe:_

____

____

____

☐ Medications (explain): ____
☐ Infectious Diseases____
☐ Other (Describe in detail): ______________________________________

	Name	Phone #	Last/Next appt.
Physician			
Dentist			
Optical			
Specialist			
Specialist			

Does the child have any suspected or confirmed developmental problems (ie: fetal alcohol exposure, ADHD, etc.) ____

____

Has the child been hospitalized since birth? ☐ Yes ☐ No

If yes, describe the reason:

____

____

<u>SOLVENT/DRUG ABUSE HISTORY</u>:

Does the child use tobacco? ☐ Yes ☐ No

Does the child use alcohol, drugs or solvents? ☐ Yes ☐ No

If yes, describe usage, age at which use started, frequency and extent: ______________________________

____

____

Describe the pattern of alcohol and drug use within the family system.

____

____

EDUCATION:

Please attach any available information regarding the youth's education (ie: academic testing, behavioural problems, suspensions, letters from teachers).

Last school attended: ______________________________

Address: ______________________________

Teacher's name: ______________________________

Program or grade level: ______________________________

Describe the child's attitude towards and behaviour in school:

____

Describe the child's academic progress: ______________________________

____

List any other schools attended, date of attendance, and grade: ______________________________

____

____

PLACEMENT HISTORY:

List all placements the youth has been in (ie: foster homes, group homes, custody facilities, relatives, etc.), the dates of the placement and the reasons for moving. (Use additional sheet, if necessary).

Placement	Dates	Reason for Move

COMMUNITY:

Has the child been involved in any illegal activity? ☐ Yes ☐ No

Have the police become involved? ☐ Yes ☐ No

If yes, list charges, court dates, and dispositions and attach relevant documentation (ie: undertaking, probation, community service orders, subpoena to witness, etc.)

___

___

___

Community Involvement (social groups, recreational, employment, volunteer, etc.):

___

___

___

Describe the child's peers: ___

Current Placement Information: (functioning, daily routines, interests, areas of strength, challenges)

List the child's major strengths: ___

___

___

List the child's major needs: ___

___

___

Does the youth show interest and motivation for a placement in the Treatment Foster Care Program?

___

___

What are the major issues for service and/or referent expectations while at Ranch Ehrlo for the child/youth and family?

1) ____

2) ____

3) ____

4) ____

What is the anticipated period of treatment? ______________________________

The following information is required prior to the youth's placement in our program.

- ☐ Health Service Card and Number
- ☐ Band Treaty Number (if applicable)
- ☐ Birth Certificate
- ☐ Social Insurance Number Card (if applicable)
- ☐ Wardship Documentation (Section 9, Long Term Order, etc.)
- ☐ Immunization record
- ☐ Copy of Probation Order, Undertaking, etc.
- ☐ Ministry Child Assessment and Development Plan
- ☐ Ministry Assessment and Case Plan
- ☐ Child Welfare Investigation Record

Please attach copies of the following assessments, if they have been completed.

- ☐ Educational and Psychological Assessments
- ☐ Psychiatric Assessments
- ☐ Comprehensive Social History
- ☐ Family Assessments
- ☐ Addictions Assessment (where applicable)
- ☐ Other: ______________________________

Please forward completed referral information to:

RANCH EHRLO SOCIETY
Intake Committee
P. O. Box 570

Attention: David Rivers
Senior Director Programs South
PILOT BUTTE, Saskatchewan
S0G 3Z0

Telephone: (306) 781-1800
Fax Number: (306) 757-0599

You will be contacted to confirm receipt of this referral.

Referent's Name: ______________________________________ Date: ____________________
(Print)

____
(Signature)

(Signature)

Referent's Supervisor: _______________________________________ Date: ____________________
(Print)

____
(Signature)