Hinton, Edson, Jasper Parent-Child Assistance Program (PCAP) Mentor Program
5123-51 Avenue, Barrhead, Alberta T7N 1A2
Ph: (780) 674-4944 Fax: (780) 674-6294

Referral Form

The Hinton, Edson, Jasper PCAP Mentor Program is a **no fee** program for at risk women. Services provided help the FASD affected women to acquire the essential supports that will allow them to build and maintain healthy lives, and to prevent alcohol and drug exposure among the future children of these mothers. To aid us in the selection process for this program, we ask that you complete the following questionnaire. **Please provide all requested information** to the best of your knowledge.

File #: _____

Name of Referred Individual: _____

Date of Birth: _____ Age: _____

Address: _____

Phone: _____

Name of Parent or Guardian: _____

Address: _____

Phone: _____

Name of Person making referral: _____

Organization/Agency/Relationship to client: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Does the Individual have a current FASD diagnosis?

Unknown Yes No Decline to Answer

If so, when? _____

By whom? _____

Did the Individual have pre-natal exposure to alcohol?

Unknown **Yes** No Decline to Answer

How do you know? _____

_____

Name of Family Physician _____

Address _____

Phone _____

Medication (medical condition/allergy) _____

Are other agencies or service providers involved?

Unknown **Yes** No Decline to Answer

Please provide the name, address and phone number _____

_____

_____

Does the Individual have any history of legal involvement? (e.g. Alternative measures, charges with crime, probation, repeat offender, incarceration, legal representation)

Unknown Yes **No** Decline to Answer

If yes, please describe _____

_____

_____

Does the Individual currently attend school? Unknown **Yes** No Decline to Answer

Name of school _____

Address _____

Phone _____ Contact Person _____

Has the Individual experienced any disruptions in their school placements?
(e.g. truancy, suspensions, expulsion, drop-out, difficult behaviours, victimization etc)

Unknown Yes **No** Decline to Answer

If yes, please describe _____

_____

_____

Has the Individual experienced disruptions/difficulties in their residential situation? (e.g. homelessness, family difficulties, financial support, exploitation, landlord/tenant issues, etc)

Unknown **Yes** No Decline to Answer

If yes, please describe _____

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_____

Is the Individual currently employed or volunteering?

Unknown Yes No Decline to Answer

Employer/Volunteer placement _____

Address _____

Phone _____ Contact Person _____

Has the Individual experienced any disruptions or difficulties in their employment/volunteer placements? (e.g. can't hold job, difficulty showing up on time, difficulty following directions, transient employment, transportation, exploitation, etc.)

Unknown Yes No Decline to Answer

If yes, please describe _____

_____

Is the Individual currently seeking employment?

Unknown Yes No Decline to Answer

Please describe the Individual's financial situation. (e.g. receiving AISH, PDD, income support, family support) _____

_____

_____

_____

Does the Individual have any history of violence? (e.g. bullying, victim of violence, unruly behavior) Unknown Yes No Decline to Answer

If yes, please describe _____

_____

_____

Does the Individual have any history of substance abuse? (e.g. involvement with alcohol, illegal or prescription drugs, addiction issues, receiving treatment, uncooperative attitude towards treatment, etc.) Unknown Yes **No** Decline to Answer

If yes, please describe _____

_____

_____

Is the Individual sexually active? (e.g. pregnancy, fathering a child, healthy sexual relationship) **Unknown** Yes **No** Decline to Answer

If yes, please describe _____

_____

Does the Individual have any history of involvement in sexual behaviour? (e.g. sexual offence, victim of sexual assault, inappropriate sexual behaviour, promiscuity, exploitation)

Unknown **Yes** No Decline to Answer

If yes, please describe _____

_____

Please describe the Individual's life skills (e.g. relationship skills, communication/comprehension skills, money management skills, grocery shopping and food preparation skills, ability to make and keep appointments, personal hygiene, positive capabilities, ability to make & keep friends, etc.) _____

_____

_____

_____

_____

Does the Individual have any history of mental health concerns? (e.g. risk taking behaviour, social isolation, depression, suicidal ideation, psychosis, obsessive compulsive disorder, eating disorders, requires medical supervision for mental health issues, taking prescribed medication for a mental health condition)

Unknown Yes No Decline to Answer

If yes, please describe _____

_____

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Please describe any other issues or concerns affecting the referred Individual.

_____

_____

_____

_____

What are you hoping to achieve for the Individual and/or their family if accepted into the Mentor Program?_____

_____

_____

_____

_____

_____

_____

Signature of Referring Person

Date

Please return this form to the appropriate address on the first page.

Statement of Permission

Permission for a referral to our program must be provided by the Individual or their guardian. Therefore, please have the Individual and their guardian sign below.

I, _____ (guardian/Individual), hereby give permission for the referral of _____(Individual's name) to the FASD Mentor Program.

_____ _____

Individual Signature Date

_____ _____

Guardian Signature Date