Counselling Services of Belleville & District

12 Moira Street East, Belleville, Ontario K8P 2R9
Phone (613) 966-7413 Fax (613) 966-2357
Email: csbd@csbd.on.ca Website: www.csbd.on.ca

FAMILY COURT CLINIC PILOT PROJECT:
CAREGIVING THROUGH CONNECTIONS
REFERRAL FORM

OUR PROGRAM

Caregiving Through Connections offers female caregivers a safe, non-judgmental space to learn and explore historical trauma and its past and present impacts on both parenting and children's development. Core values of the program include providing a service that meets mothers where they are at; building awareness and resilience, and mitigating factors that interfere with the health of the attachment relationship and child development.

REFERRAL CRITERIA

- ☐ Are the primary caregiver of at least one child, under the age of 6.
- ☐ Are involved in child welfare.
- ☐ Have experienced childhood trauma/abuse and/or victimized within an adult relationship.
- ☐ Have stable housing and marital status.
- ☐ Are not currently active in drug use/addiction.
- ☐ Are motivated and willing to participate in 16 weeks of intervention.
- ☐ Are able to keep regular appointments and attend in a timely manner.
- ☐ Have the capacity to participate in group learning and reflection.

REFERRING AGENCY DETAILS

Referral Date _____ Agency _____

Agency Worker _____ Phone _____

Email _____

Supervisor _____ Phone _____

Email _____

CAREGIVER DETAILS

First Name _____ Last Name _____

Pronoun _____ D.O.B. _____

Address _____

City _____ Province _____ Postal Code _____

Phone _____ Email _____

Preferred contact method ☐ Phone ☐ Text ☐ Email

Can a message be left on the phone ☐ Yes ☐ No

Accommodation needs ☐ Yes ☐ No

If yes, provide details _____

CURRENT PARENTING SITUATION

Child(ren) are residing ☐ At home ☐ Kinship ☐ In care ☐ TCA

Access Involvement ☐ Yes ☐ No

If yes, what is the supervision level ☐ Full ☐ Semi ☐ None

Person supervising & relationship _____

Other Services involved

SUPPORTING DOCUMENTS

In addition to completing the above information, if applicable, please provide the following documentation:

- ☐ Highland Shores Children's Aid Society application before the court
- ☐ Summary of current family concerns, as well as identified concerns/needs for access visits
- ☐ Harm/Danger Statement, safety goals, and/or safety plan
- ☐ Referral source comments or additional relevant information

DECLARATION AND CONSENT

By signing below, I confirm I have read and reviewed this referral, and agree with its submission.

_____ _____

Caregiver Date

_____ _____

Witness Date

REFERRAL SUBMISSION

Please submit this completed form, along with the requested supporting documents to:

Sara Hamilton Email: sara.hamilton@csbd.on.ca Fax: (613) 966-2357

You will receive an email confirming receipt.