CSBD
Community Services
OF BELLEVILLE
AND DISTRICT

REFERRAL

Family Court Clinic: Pilot Project
Caregiving Through Connections

Referral Date: _____

Name: _____

D.O.B.: _____ **Pronoun:** _____

Address: _____ _____ _____
Street City Postal Code

Contact: _____ _____ _____
Home Cell Email

Preferred contact method: ☐ Phone ☐ Text ☐ Email

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

Referral Source Information

Name: _____ **Agency:** _____

Email: _____ **Phone:** _____

Supervisor: _____ **Phone:** _____

Referral Criteria:
Applicant must meet all of the following criteria:

- ☐ Primary caregiver of at least one child, under the age of 7
- ☐ Have current or past involvement in Child Welfare
- ☐ Experienced childhood trauma/abuse and/or victimized within an adult relationship
- ☐ Current housing and marital status is stable
- ☐ Not currently active in drug use/addiction
- ☐ Motivated and willing to participate in 16 weeks of intervention
- ☐ Able to keep regular appointments and attend in a timely manner
- ☐ Capacity to participate in group learning and reflection

Referral Reason:

12 Moira Street East, Belleville, ON K8P 2R9
Tel: 613-966-7413 ● Fax: 613-966-2357 ● Toll Free: 1-800-966-7413
Email: csbd@csbd.on.ca ● website: www.csbd.on.ca

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

Information

Accommodation needs: ☐ Yes ☐ No

If yes, please detail: _____

Other Agencies or Supports:

Name/Title	Agency	Phone

Other Information:
(i.e.: medication, family information, funding such as ACSD, SSAH)

Documentation included with referral:

☐ Consent to Share Information – for all agencies listed above

☐ Trajectory / Signs of Safety documentation

☐ _____

☐ _____

Declaration & Consent

By signing below, I confirm I have read and reviewed this referral and agree with its submission. I understand that upon receipt of the referral, CSBD will open an electronic file in my name.

_____ _____
Person Referred Date

_____ _____
Referring Person Signature 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.