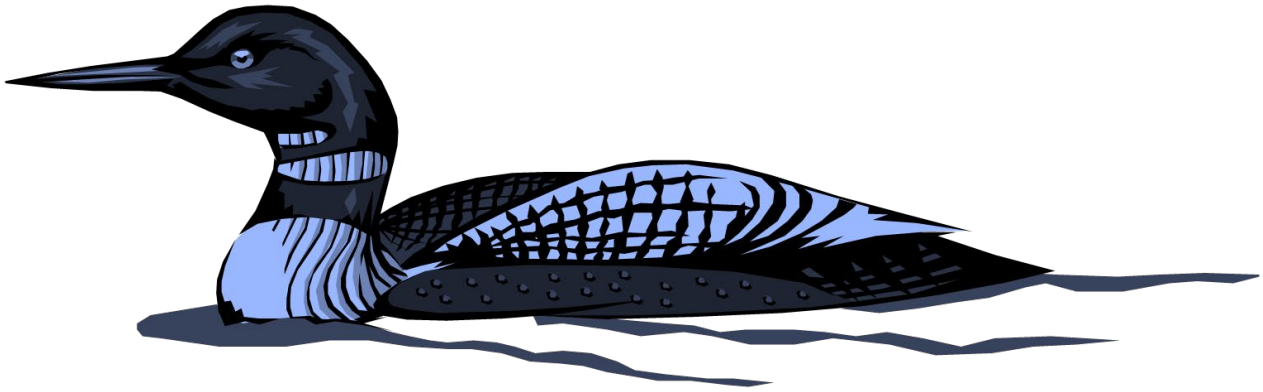
WEECHI-IT-TE-WIN FAMILY SERVICES
FAMILY HEALING PROGRAM

"We believe in the traditional Anishinaabe concepts of family and as such, we work together to help families heal and attain "mino bimaadiziwin" (a good life)."



BRIEF REFERRAL/SCREENING FORM

Location: 71 McTavish Rd., Devlin, Ontario

Address: P.O. BOX 812, Fort Frances, Ontario, P9A 3N1

Telephone: 807-486-1618 or 807-274-3201, ext. 1006, or 1-866-656-4460

Fax: 807-486-1761

Email: heidi.bolen-kreger@weechi.ca

Manager: Edward Yerxa
Intake Coordinator: Heidi Bolen-Kreger

Brief Referral/Screening

Client (Family) Name: _____

Mother's Name: _____ D.0.B.: _____
(Client – Female)
Band Name: _____ Band Number: _____

Street Address: _____

Mailing Address: _____

Telephone Number: _____ Email: _____

Father's Name: _____ D.0.B.: _____
(Client – Male)
Band Name: _____ Band Number: _____

Street Address: _____

Mailing Address: _____

Telephone Number: _____ Email: _____

Children's Name_____ D.O.B.: _____

Children's Name_____ D.O.B.: _____

Children's Name_____ D.O.B.: _____

Children's Name_____ D.O.B.: _____

Children's Name_____ D.O.B.: _____

Referral Agency: _____

Worker: _____

Phone Number and Email: _____

Reason for Referral:

Is there Child Welfare involvement with the family? (example: open protection or; family treatment is required for family reunification; returning care and custody of children/youth**? Please provide Details:**

Are **<u>all</u>** members of the family **voluntarily** willing to participate in the Family Healing Program? **If not, which family members are not willing and why?**

Are any family members currently or more recently (in the last 90 days) misusing any substances? **(Please list who is using, what they are using, frequency and last use):**

Have any family members participated in treatment services before (can include residential or outpatient). **If yes, complete the following chart.**

Name	Treatment Centre	Year Attended	What did you learn from the program?

Is Client currently participating in a withdrawal management program? (Methadone, Saboxone, etc.)

Have you, or anyone in your family, experienced trauma? This could include significant losses, events, circumstances. **If yes, please explain:**

Grief:

Abuse:

Relationship:

Separation:

Abandonment:

Other:

Does any family member have a history of violent or aggressive behaviors which would pose a risk to staff or other participants of the Family Healing Program?
☐Yes ☐No If Yes, please list who is, and explain:

Does any family member/s have a history of sexual offence(s)?
☐Yes ☐No If Yes, please share who, what they did, when, and the outcome.

Has any family member/s been either a victim of, or a perpetrator of violence? **☐Yes ☐No**
Please provide details (Who, what type(s) of violence, when, what was the outcome?

Are any member/s of the family **currently** facing legal charges?
If yes, provide details (who, what are the charges, when is their court appearance):

Legal History: Date: Outcome:

Does any family member/s have significant mental health issues that would be better treated by a psychologist or psychiatrist? **If yes, please list who and explain:**

Are any family members currently or historically at risk of suicide (suicidal thoughts, statements, threats, attempts) **OR** engaging in self-harm behaviours? **If yes, please provide specific details to incidents (present and past)**

Are any member/s of the family currently on any medications? I**f yes, complete the chart.**

MEDICATION NAME	DOSAGE	HOW LONG PRESCRIBED	REASON

*Any additional medications can be attached.

	Signatures	Date
Signature of Client		
Signature of Referral Source		