Referral Intake Form

Family Services: SNAPP

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake Information

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| --- | --- | --- | --- |
| Name of Referring Social Worker: | | | |
| Office: | | Telephone: | |
| **Name of Referred Participant(s) Date of Birth Legal Status** | | | |
|  |  | |  |
|  |  | |  |
|  |  | |  |
| Type of Referral Request: (Check all that apply)  \_\_\_ Adoption/Permanency Planning \_\_\_ Birth Family Support  \_\_\_ Foster Family or Caregiver Support \_\_\_ Post-Adoption Support  \_\_\_ Adoptive Family Support \_\_\_ Concurrent Planning Referral  \_\_\_ Direct Work With Child(ren) \_\_\_ Lifebook Work  \_\_\_ Transitioning/Pre-placement Support \_\_\_ Processing of Difficult History  \_\_\_ Birth Family History \_\_\_ Understanding Different Families  \_\_\_ Consultative/Other – Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

Family and Household Information

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| --- |
| Current Caregiver:  foster/adoptive/other- specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name(s) of current caregivers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Resource Social Worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Address of Participant Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: |

**2. SNAPP work Requested as Identified by the Referring Worker**

|  |  |  |
| --- | --- | --- |
| NEEDS | Worker | Participant |
| Transition and Pre-Placement Planning |  |  |
| Lifebook Work |  |  |
| Life History and Making Sense of the Past |  |  |
| Processing Difficult Information (including reasons for being in care) |  |  |
| Building Sense of Self and Self-Esteem |  |  |
| Identifying and Understanding Feelings |  |  |
| Grief and Loss Support |  |  |
| Developing Coping Skills |  |  |
| Understanding Different Kinds of Families |  |  |
| Preparation of Child for Adoption and Permanency Transition |  |  |
| Support for Child During Adoption and Permanency Transition |  |  |
| Preparation and Support of Foster or Present Caregiver Family in Transitioning |  |  |
| Preparation and Support of Adoptive Family in Transitioning |  |  |
| Post-Placement Support |  |  |
| Support in Building Attachment |  |  |
| Support and Affirmation in Parenting |  |  |
| Placement Disruption – Debriefing and Support |  |  |
| Cultural Support (specify) |  |  |
| Other (specify) |  |  |
| Other (specify) |  |  |
| Other (specify) |  |  |

**3. Support Requirements and Risk Factors of Child/Youth Participant**

Check all that apply:

|  |  |
| --- | --- |
| **Support Needs and Risk Factors** | **Describe** |
| \_\_\_ Require sibling placement |  |
| \_\_\_ Require cultural match |  |
| \_\_\_ History of neglect |  |
| \_\_\_ History of physical abuse |  |
| \_\_\_ History of abandonment |  |
| \_\_\_ History of sexual abuse |  |
| \_\_\_ Sexualized Behaviors |  |
| \_\_\_ Physical limitations |  |
| \_\_\_ Developmentally delayed or Low I.Q. |  |
| \_\_\_ Autism Spectrum |  |
| \_\_\_ Previously diagnosed with “Failure to Thrive” |  |
| \_\_\_ Birth family history of mental illness |  |
| \_\_\_ Birth parent mentally challenged |  |
| \_\_\_ History of degenerative illness |  |
| \_\_\_ FASD |  |
| \_\_\_ Neonatal Abstinence Syndrome |  |
| \_\_\_ Prenatal exposure to drugs |  |
| \_\_\_ Prenatal exposure to alcohol |  |
| \_\_\_ ADHD |  |
| \_\_\_ PTSD |  |
| \_\_\_ Multiple Placements |  |
| \_\_\_ Attachment Disordered |  |
| \_\_\_ Aggression |  |
| \_\_\_ Anxiety |  |
| \_\_\_ Challenging Behaviors |  |
| \_\_\_ Poor Self-Regulation |  |
| \_\_\_ Other (specify) |  |

**4. Reasons Child is in Care:**

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Additional information around child’s strengths, abilities and special needs

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|  |

Set Initial Team Planning Meeting Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Target Referral Activation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Further Notes:

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