

REFERRAL INFORMATION ERMA'S HOUSE
(TO BE COMPLETED BY THE REFERRAL SOURCE - NOT THE CLIENT)

DATE: _____ CONTACT PERSON: _____

REFERRAL FROM: _____

ADDRESS: _____

PHONE: _____ FAX: _____ E-MAIL: _____

IDENTIFYING INFORMATION

RESIDENTIAL PARENT/PARTY

NON-RESIDENTIAL PARENT/PARTY

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

PHONE: _____

PHONE: _____

RELATIONSHIP TO CHILD: _____

RELATIONSHIP TO CHILD: _____

CHILD(REN) PLEASE LIST NAME AND AGES OF THOSE WHO WILL BE INVOLVED IN PARENTING TIME VISTS

CHILD: _____

CHILD: _____

AGE: _____

AGE: _____

CHILD: _____

CHILD: _____

AGE: _____

AGE: _____

REASON FOR SUPERVISION OF PARENTING TIME/VISITS: _____

SERVICES REQUESTED:

_____ Supervised Parenting Time/Visitation
_____ Supervised Parenting Time/ Exchanges

Length of Parenting Time:

_____ 60 Minutes
_____ 90 Minutes
_____ 120 Minutes

Recommendation as to **FREQUENCY** of Supervised Parenting Time:

_____ 1 x per week
_____ 1 x every other week
_____ Other: _____

Recommendation as to **LEVEL** of Supervision: **CHECK ONE:**

_____ Level 1 - Monitor in room with family at all times.
_____ Level 2 - Monitor outside/nearby room checking in every 10 minutes.
_____ Level 3 - Monitor outside/nearby room checking in every 30 minutes.

SPECIAL NEEDS OF THE CHILDREN: _____

Is there a **PROTECTION ORDERS** in place? _____ **NO** OR _____ **YES** if yes, please specify: _____

Special **PROBLEMS** to watch for: *(include behavior, medical, attitudinal, etc. of any family member)*

Supervised Exchanges Only

SPECIFICATIONS for Drop-Off/Pick-Up *(i.e. days & times)* _____

Is there a GAL or CASA involved? *Please provide the name, address and phone number.*

Requested frequency of reports: _____

ADDITIONAL INFORMATION: _____
