CIRCLE OF CARE
WABANO CENTRE FOR ABORIGINAL HEALTH
299 MONTREAL ROAD,
OTTAWA, ONTARIO, K1L 6B8

CIRCLE OF CARE REFERRAL FORM

Referral Date:

Name of Person Referring: **Referring Agency:**

Telephone: **Email:**

Reason for Referral:

Is the family aware a referral to Circle of Care is being made? Yes ☐ No ☐

FAMILY INFORMATION

Parent Name: **Date of Birth:**
Address:
Telephone Number: **Email:**
First Nation ☐ Inuit ☐ Métis ☐ **Status ☐ Non-Status ☐**
Non-Indigenous ☐

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Address:
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Child Name: **Date of Birth:**

Living with: Parents ☐ Kin ☐ Foster Parent(s) ☐

If apprehended, please specify date of apprehension: _____

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Living with: Parents ☐ Kin ☐ Foster Parent(s) ☐

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Child Name: **Date of Birth:**

Living with: Parents ☐ Kin ☐ Foster Parent(s) ☐

If apprehended, please specify date of apprehension: _____

CAS INFORMATION

Child Protection Worker:
Telephone: **Email:**

CAS Supervisor:
Telephone: **Email:**

When did the file open with CAS: _____

Is the family working voluntarily with CAS? Yes ☐ No ☐

Is there an upcoming court date? Yes ☐ No ☐

If yes, please specify date: _____

What is the goal of the upcoming court date:

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Has the parent(s) signed consent to disclose information to Circle of Care: Yes ☐ No ☐

**** If yes, please forward the consent form with the referral form.***

Additional Notes:

Please attach any additional documents to this referral if necessary, including case summary, Plan of Service, Voluntary Service Agreements and Court Orders. Additional documents should only be forwarded on the condition that the parent has signed consent to disclose information to COC before an intake has been completed.

Please send completed referral form to:

Gina Metallic, MSW, RSW.
Circle of Care Coordinator
Telephone: 613-748-0657 ext 238
Fax: 613-749-1195
Email: gmetallic@wabano.com