

Confident Parents Thriving Kids

Physician Referral form

Confident Parents: Thriving Kids is a telephone based coaching service for parents proven effective in reducing mild to moderate behavioural problems in children ages 3–12.

Please complete the following and fax to 1-877-688-3270 or email to confidentparents@cmha.bc.ca. Only completed referral forms will be accepted.

Please print: Referral date: _____ PHN: _____

Child's name: _____ Date of birth: _____ Gender: M F Other _____
(MM/DD/YYYY)

Parent/Guardian name: _____ Relationship to child: _____

Note: If caregiver is not the child's legal guardian, consent from the legal guardian is required to participate in this program.

Parent/Guardian mailing address: _____ City: _____ Postal Code: _____

Home phone number: _____ Cell phone: _____ Email address: _____

Referring physician name: _____ Phone: _____ Fax: _____

Mailing address: _____ City: _____ Postal Code: _____

Pediatrician Family Doctor Other _____ (please specify)

Inclusionary Criteria

- Please confirm that the child:
- Is between the ages of 3–12.
 - Is exhibiting ongoing mild or moderate conduct problems that negatively impact family functioning, or outcomes in school / community.
 - Resides with referring parent a minimum of 50% of the time.

Exclusionary Criteria

- Please confirm:
- The referring parent is **not** experiencing any significant impairments or extenuating circumstances that would inhibit their ability to participate in a weekly parenting program.
 - The child has **not** been diagnosed with FASD, autism spectrum disorder, or significant intellectual impairments or cognitive delay.
- For information purposes: is a diagnosis pending for one of the conditions above?
- Yes No (Please note that pending diagnoses may not preclude participation)
- The child does **not** exhibit severe to extreme impairment in mood, emotion, self-harm or substance use.

Please note: All of the above criteria boxes must be checked to be eligible for referral.

Physician comments

Physician signature to
approve referral:

Parent must fill out this section

I, _____ (parent name, please print) understand that I have been referred to Confident Parents: Thriving Kids and that (please initial):

_____ It is a positive parenting program

_____ It is telephone based coaching

_____ It requires a minimum 6 week commitment for consecutive weekly 50-minute telephone sessions

Parent signature to
consent to referral: _____