

FAMILY SUPPORT AND VISITATION CENTER
239 West Main Street
Lancaster, OH 43130
Phone: 740-681-7243
Fax: 740-687-6735

REFERRAL FORM

Please complete the following information:

Court Location: _____ Case Number: _____

Referral Source: _____ Reason for Referral: _____

Person Completing Form: _____ Date: _____ Phone Number: _____

Service Requesting: _____ Parenting Time (Supervised Visits) _____ Monitored Exchanges

Recommended Level of Supervision for Parenting Time:

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.

Level 4 Monitor outside/nearby room, available if needed.

***CS Caseworkers: (*To be completed by Children Service caseworkers and/or supervisors*)**

Caseworker Name _____ Phone _____ Case# _____

Monitor by camera ___yes___ ___no___ Court Involvement ___yes___ ___no___

Number of visits per week _____ Length of each visit _____

Circle one: One Time On Going If on going, length of time anticipated _____

Any family members that may not visit: _____

Visits will begin as soon as possible unless stated here _____

ProtectOHIO ___yes___ ___no___

Party A: Parent(s) / Adult(s)

If applicable, list residential parent first (A1).

A1

Name

Address

Age and Date of Birth Race / Ethnicity Social Security Number

City – State – Zip Code

Home Telephone # Cell #

Employment

Work Phone (Can we call there?)

Work Schedule

Attorney Attorney Phone #

A2

Name

Address

City – State – Zip Code

Age and Date of Birth Race / Ethnicity Social Security Number

Home Telephone # Cell #

Employment

Work Phone (Can we call there?)

Work Schedule

Attorney Attorney Phone No.

Party B: Child / Children

List each child separately.

B1

Child's name, age/DOB SSN

Name/type of residence (e.g., foster parents, agency, #)

Address

Telephone #

Foster parent agency Contact/ #

B2

Child's name, age/DOB SSN

Name/type of residence (e.g., foster parents)

Address

Telephone #

Foster parent agency Contact/ #

B3

Child's name, age/DOB SSN

Name/type of residence (e.g., foster parents, agency, #)

Address

Telephone #

Foster parent agency Contact/ #

Special Problems/Concerns to watch for (include behavioral, medical, attitudinal, etc., of any family members) re: SA, PA, Neglect Issues, and Safety Issues

Case History/Case Worker Expectations of Client

FAMILY VIOLENCE SCREENING:

Prior arrest including weapons? _____ **Yes** _____ **No**
Protective Order/Restraining Order? _____ **Yes** _____ **No**
Are the Parties able to mediate? _____ **Yes** _____ **No**

MARITAL STATUS:

_____ **Never married** _____ **Married** _____ **Separated** _____ **Divorced**

Who is responsible for payment of services?

_____ **Residential party** _____ **Non-Residential party** _____ **Split equally**

SUPPORT ORDER IN PLACE: _____ **Yes** _____ **No**

CHILDREN SERVICES INVOLVEMENT: _____ **Yes** _____ **No**

Are you requesting * Enhanced Visitation* services for this family? _____ **Yes** _____ **No**

- Enhanced Visitation – utilizing “teachable moments” to assist individuals in strengthening their parenting abilities in order to promote a safe and healthy parent/child relationship.**