The Toby Center

Agency Referral Form

Supervised Visitation and Therapeutic Supervised Visitation

Client Name _____ Case Number (if court referred) _____
Referred by _____ Reason _____
Agency Name _____Contact Person _____
Case Manager _____Contact email/tel._____
GAL _____ Contact email _____

What is/are goal(s) for the therapeutic visitation?

_____
_____
_____
_____

☐ Palm Beach County	☐ Broward County	☐ Other _____

Case Name:	**Placement:** ☐ Relative ☐ Non-Relative ☐ Foster Parent	
	Caregiver Name:	Caregiver Phone Number:
	Caregiver Address:	

Were the child(ren) sheltered within the last 28 days?	☐ Yes	☐ No
If Yes, Did the child(ren) visit with the parent(s) within 72 hours of being sheltered?	☐ Yes	☐ No
If No, Has a visit been scheduled since the shelter hearing?	☐ Yes	☐ No
If a visit has/will **not** be scheduled within 72 hours of shelter, please select the reason(s):		
☐ Unable to locate parent	☐ Failure to appear	
☐ No-contact order	☐ Parent incarcerated	
☐ Tested positive/Substance misuse	☐ Other:	

Why is there need for therapeutic supervised visitation?

_____
_____
_____

Is this court ordered or voluntary? _____ **If Court Ordered, please forward the Court Order to email ekc1019@yahoo.com (if agency referred) or clberko@aol.com if private pay. Or fax to 561-300-8587.

Are you creating a transportation Request? ☐ Yes ☐ No	If no, who is approved for transportation:

Child(ren):	Date of Birth:	Last 4 Digits of SSN:	Gender:
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

Court Approved Visitors:

Name:	Date of Birth:	Last 4 Digits of SSN:	Relationship:

Does the visitor have permission to take pictures? ☐ Yes ☐ No	Is the current case plan goal reunification? ☐ Yes ☐ No

Visitation Schedule Requested Per Court order:

Hours per visit:	Days Per week:

Alleged Maltreatment(s):

☐ Physical Abuse	☐ Sexual Abuse	☐ Neglect
☐ Domestic Violence	☐ Failure to Protect	☐ Mental Injury

Person Alleged Responsible for the Maltreatment:

Name:	Relationship:

Please check any problems the family may be experiencing:

Parental:	Marital:	Other:
☐ Adolescent Control	☐ Divorcing/Separating Parents	☐ Alcohol and/or Drug Misuse
☐ Showing Affection	☐ Time Spent Together	☐ Unemployment
☐ Toileting	☐ Ex-Husband or Wife	☐ Transportation
☐ Rules	☐ Violence Between Parents	☐ Expressing Feelings
☐ Fighting Between Kids	☐ Making Decisions	
☐ Other:		

Please indicate any of the following special circumstances:

☐ Mental Illness	☐ Developmental Challenges	☐ Risk of Abduction
☐ Special Safety Precautions Needed	☐ Criminal History	☐ Urinalysis Contingent
☐ Other:		

Please explain any known medical conditions of the child(ren):

Child:	Condition:	Medication:	Dosage/Frequency:

Are the children taking medication? Y/N For what condition? _____
If yes, what medication? _____ Dosage _____

Does a child have any physical constraints, food allergies, mental health issues we should know about? _____

**** Please note that the Toby Center staff are not to administer medication. Also, Toby Center staff are to be held harmless for any medical condition which may arise. Staff know to call 911 for any problem that cannot be administered to immediately on site.**

_____ Client Initials Client understands that the Toby Center has limited liability for any form of supervised visitation. Staff must be informed of challenges, health and mental capacity considerations to assure the client of a meaningful and safe visitation.

Please describe any other concerns or special considerations:

Service Type:

☐ **Supervised Visitation** Supervision provided in setting by individual facilitator for each family.
☐ **Secure Visitation** A Court ordered service provided on an individual basis by qualified providers with a maximum of a 1:1 staff to family ratio. This service is provided when background factors (history of sexual abuse, domestic violence, or difficulty adjusting to visitation) are of concern. Provision of this service is not contingent on a diagnosis. *You may also request Enhanced Visitation services with Secure Visitation.*
☐ **Therapeutic Visitation** Court order or agency directive or other agreement requires licensed mental health practitioner to facilitate the supervised visitation. Though Therapeutic Visitation is not therapy, the process is therapeutic. Family Monitors are therapists with the responsibility to help achieve more normalized relationships pursuant to the goals of this visitation. Toby Center therapists do not diagnose, but may find conditions to aid in this process. Documents related to this service are protected by HIPPA.
☐ **Electronic Virtual Visitation** Supervision provided for families to visit electronically across great distances using a webcam, telephone, or other web-based tool. Supervision is provided by qualified Family Monitor. This service requires coordination with external resources.

Reports:

Requests for field and or other reports must be made directly to the Family Monitor or Therapist servicing this case. Client data is confidential and remains in client file. All therapeutic reports are subject to HIPAA; ask your therapeutic provider for their current policy. Field notes are available only through subpoena to the Family Monitor or Therapist. They will provide their policy for providing Field Notes.

Print Name of Authorizing Individual	Phone Contact:	E-Mail Address:
Referring Agency Office County	Date Referral Sent:	

Signature _____ Title _____Date _____

Therapeutic Visitation Intake - Supplement

Child(ren):	**Diagnosis:**

Parent(s):	**Diagnosis:**

Please describe how the mental health diagnosis has negatively impacted the family environment:

Are children or any adult currently receiving counseling? ☐ **Yes** ☐ **No**

Please list counseling current provider(s):

Person Receiving Services	**Provider Name**	**Contact Information**

Signatures:

Client _____ **Date** _____

Toby Center Rep _____ **Date** _____