Confident Parents
Thriving Kids

Canadian Mental Health Association
British Columbia
Mental health for all

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:** _____ (MM/DD/YYYY) **Gender:** ☐ M ☐ F ☐ Other _____

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: _____

Confident Parents: Thriving Kids is offered in partnership with Implementation Sciences International Inc.
Funding for Confident Parents: Thriving Kids provided by the Province of British Columbia