BUDS IN BLOOM

*CONFIDENTIAL*

# NEW FAMILY QUESTIONNAIRE

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **CHILD'S NAME** | LAST | | | | FIRST | | | |
| **DATE OF BIRTH** | YEAR | | MONTH | | DAY | | CHRONOLOGICAL AGE | |
| **DIAGNOSIS(ES)** [if known] | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| **SCHOOL or DAYCARE** | NAME | | | | | | | |
| | ADDRESS | | | | | | | |

| | | |
|---|---|---|
| **AGENCY/ORGANIZATION/ PERSON REFERRING TO OUR ORGANIZATION** | NAME | |
| | TITLE | |
| **PAEDIATRICIAN** | NAME | |
| | TEL | |
| **MEDICARE #** | | |
| **OTHER INSURANCE #**(PRIVATE) | | |

## PARENTS(GUARDIANS)

| | | | |
|---|---|---|---|
| **MOTHER**(GUARDIAN) | | **FATHER**(GUARDIAN) | |
| **LANGUAGE(S)** VERY WELL UNDERSTOOD | ☐ English ☐ French | **LANGUAGE(S)** VERY WELL UNDERSTOOD | ☐ English ☐ French |
| OCCUPATION | | OCCUPATION | |
| HOME Tel # | | HOME Tel # | |
| WORK Tel # | | WORK Tel # | |
| CELL Tel # | | CELL Tel # | |
| POSTAL ADDRESS | | POSTAL ADDRESS | |
| | | | |
| E-MAIL | | E-MAIL | |

**Administrative section, for internal use only** ☐ WAIT TIME _____ ☐ REPORT(S) ☐ CQ ☐ BQ ☐ FEES PROCESSED

Access to PPP (OT, SLP, workshop, etc. in order agreed at meeting): 1- _____
Referred to (name and title)

2- _____ 3- _____ 4- _____
Referred to (name and title) Referred to (name and title) Referred to (name and title)

Suggested visit frequency per resource: 1- _____/ yr 2- _____/ yr 3- _____/ yr 4- _____/ yr

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **REQUEST RECEIVED** | YYYY-MM-DD | **FEES PROCESSED** | YYYY-MM-DD | **1st REFERRAL** | YYYY-MM-DD (specify resource) | **SURVEY FOLLOW-UP** | YYYY-MM-DD |

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## NEW FAMILY(CONTINUED)

**My child lives at home with** (specify the number per category):

Sister(s): _____(age(s): _____) Brother(s): _____(age(s): _____) Parent(s):_____

Animal(s) and type(s):

_____

**My child participates in other programs** (ex. "Gym and swim", therapy, sports, etc.):

_____

_____

_____

_____

**First words of my child or none yet:**

_____ At what age? _____

**First steps by my child or not yet:**

At what age? _____

**Main languages(s) spoken at:**

**Home:** _____ **Daycare or school:** _____

**My child is allergic to** (please specify):

_____

**My child takes or has taken medication** (please specify):

Presently: _____

In the past: _____

**My child's strengths or skills are** (please describe them and add a sheet if more space is needed):

_____

_____

_____

**My child's favourites are** (please give examples of preferred interests, activities, objects, games, foods, etc.):

_____

_____

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## NEW FAMILY(CONTINUED)

**My child's weaknesses are** (please describe them and add a sheet if more space is needed):

_____

_____

_____

**My child uses aggressive or violent behaviours with self or others** (please describe them and add a sheet if more space is needed):

_____

_____

_____

**There were hospitalizations, illness(es) or other <u>birth</u>/ medical history in my child's life** (please describe them and add a sheet if more space is needed):

_____

_____

_____

**Past or present service(s) my child received*:** (check **<u>ALL</u>** boxes that apply)

Presently: ☐ occupational therapy ☐ speech-language pathology ☐ physiotherapy ☐ psychology
☐ psycho-education ☐ special education ☐ other (specify) : _____

In the past: ☐ occupational therapy ☐ speech-language pathology ☐ physiotherapy ☐ psychology
☐ psycho-education ☐ special education ☐ other (specify) : _____

**<u>My child</u> and/ or <u>our family</u> probably need this or these type(s) of service:** (please describe them and add a sheet if more space is needed): (check **<u>ONLY ONE</u>** box)

☐ I don't know ☐ Probably these services: (please describe them and add a sheet if more space is needed) :

_____

_____

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## NEW FAMILY(CONTINUED)

**My hopes for my child and our family are** (please describe them and add a sheet if more space is needed):

_____

_____

Next, on the line from 1 to 10, trace **ONLY ONE X** on the frequency that is most representative of:

**Stress or worry** experienced by our family

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Almost never | | | | | | | | | Almost always |

**Hope** experienced by our family

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Almost never | | | | | | | | | Almost always |

Feeling of being **empowered** experienced by our family

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Almost never | | | | | | | | | Almost always |

Feeling of being **helped** experienced by our family

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Almost never | | | | | | | | | Almost always |

**My child can be seen at:** (check **ALL** that apply**)**

☐ Home ☐ at a clinic (address will be confirmed by the network partner to whom we will refer you)

☐ Daycare or school (specify address): _____

*N.B: The more flexible you are with the location of service and scheduling, the faster your child will receive a specialized service.*

**Probability of the need for supplemental funding for our family:** (check **ONLY ONE** box)

☐ Now ☐ In the next 3 months ☐ In more than 3 months

☐ Other comments (please share):_____

**Names of person(s) who completed this form**:

_____

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# PRIVACY POLICY

**CHILD'S NAME:** _____

**Our Privacy Policy**

Various laws exist governing the collection and use of personal information. Therefore, we (Buds in Bloom) must advise you of the following:

1) When opening a file, we collect, from you or other third parties, certain information concerning you, your family or your child (personal information), and put it in your file. Only employees and agents of Buds in Bloom (for example, medical and health care professionals that are part of our network of partners) who require access to your file, as part of their duties, have access to this information. We use your personal information to be able to:
   - Determine your eligibility for our services;
   - Identify what services are appropriate for your needs, according to your family resources, and to available help resources in your geographic region;
   - Share this information with network partners and help resources that are assigned to your family
   - Enable us to provide the services you requested.

2) We may have to call upon third parties, with your agreement (for example, doctors or other therapists) that hold personal information concerning you to complete the information in your file.

3) We may sometimes share your personal information with third parties (not usually part of our network of partners) as to fulfill the mandate entrusted to them. Your consent will be requested prior to doing so.

4) Buds in Bloom is committed to collecting and using your personal information only within the limits of the description provided, holding it securely and only as long as you do business with us.

I, the undersigned, hereby acknowledge that I have read and understood the above policy.

| | | | |
|---|---|---|---|
| MOTHER (GUARDIAN) SIGNATURE | | DATE | |
| FATHER (GUARDIAN) SIGNATURE | | DATE | |

**N.B.: The written authorization and signature of both parents, or guardians, are strongly encouraged to process your request.**

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# CONSENT TO SHARE POLICY

**CHILD'S NAME:** _____

**Our Consent to Share Policy**

In light of the Privacy Policy, and to process your request, we (Buds in Bloom) ask your consent to forward this completed family questionnaire and the boursary questionnaire to the respective Buds in Bloom network partners or help resources assigned to your child or family.

1) The family questionnaire (CQ) is shared with network partners and help resources that can support my child or family with a specialized service, workshop or financial help.

2) The boursary questionnaire (BQ) is only shared with partners who can inform or support your family financially.

I, the undersigned, hereby acknowledge that I have read and understood the consent to share policy.

| | | | |
|---|---|---|---|
| MOTHER (GUARDIAN) SIGNATURE | | DATE | |
| FATHER (GUARDIAN) SIGNATURE | | DATE | |

**N.B.: The written authorization and signature of both parents, or guardians, are strongly encouraged to process your request.**

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# POLICY TO RECEIVE INFORMATION

**CHILD'S NAME:** _____

**Our Policy to Receive Information**

Buds in Bloom offers not only rapid access to a **specialized service**, but also information about workshops, news and events for the well-being of children and their family.

1) We (Buds in Bloom) ask for your consent to add your contact information to the mail list for us to be able to offer you this added service.
2) Note that your name and contact information will remain private, and will not be shared with anyone without your written consent.
3) Note that you can remove your name from the list at any time by writing us an email.

I, the undersigned, hereby acknowledge that I have read and understood the policy to receive information.

Check **ONLY ONE** box per person.

| **MOTHER (guardian)** | | **FATHER (guardian)** | |
|---|---|---|---|
| ☐ No (go to the signature and date)<br>☐ Yes (specify your email address in the space below) | | ☐ No (go to the signature and date)<br>☐ Yes (specify your email address in the space below) | |
| Email address | ☐ The same as indicated on page 1 | Email address | ☐ The same as indicated on page 1 |
| Other email address | | Other email address | |
| **Signature** | | **Signature** | |
| **Date** | | **Date** | |

Last, take note that we (Buds in Bloom) may communicate with you after you are referred, to ensure the quality of access to a **specialized service**, as well as the service you referred to. Your opinion is important to Buds in Bloom.

Please go to the final page.

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Make sure to accompany this questionnaire with the following three items:

- ☐ All medical, educational and school reports within the last 12 months;
- ☐ The Financial Health – Boursary Request questionnaire;
- ☐ A check covering the administrative fees, according to the option selected (see the Financial Health – Boursary Request form). The administrative fee is required **ONLY ONCE** to open a file, analyse the needs and resources of your child and family, as well as refer you to a network partner in your geographic region.

  Please make the check payable to Buds in Bloom.

  If your family is not eligible for our services, the administrative fee will not be processed. However, if your family is eligible for our services, our promise is to offer your child or family **access to a specialized service** in less than two months following the date that all previously mentioned items are processed.

  **IMPORTANT!** Please return the original questionnaire completed (**copies are not accepted**), accompanied by the three aforementioned items to:

c/o Abby Kleinberg-Bassel for Buds in Bloom
5250 Ferrier Street, Suite 801
Montreal (Quebec) H4P 1L4

Creating a **Canada** where every family living with special needs gets help today, since 2011.

**For the best family start ©**