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FAMILY VISITATION PROGRAM
REFERRAL FORM

Case Name: ______________________________________ FSFN ID: __________________
Case Manager: ___________________________ Phone:______________ Agency: _______
Supervisor: ______________________________ Phone:______________

Visitation Center- Is a specific center required, if so please select from the below choices:
(If no location is selected, we will reach out to all participants, to determine the best location for all parties)

☐ Osceola Visitation Center: 111 E. Monument Ave. Kissimmee, Fl 34741
☐ West Orange Visitation Center: 5749 Westgate Dr. Orlando, Fl 32835
☐ East Orange Visitation Center: 4001 Pelee St, Orlando, FL 32817
☐ Seminole Visitation Center: 2919 S Orlando Dr. Sanford, Fl 32773

Is this visit approved for the Community? Yes ☐ No ☐
Are Visits Court Ordered to be Video Taped: Yes ☐ No ☐

Visitors:

Children	Age		Primary Visitors	Relationship

Case Information:

Reason for Case Initiation:	
Perpetrator:	
ANY Safety Concerns:	
Special Needs:	

Please Check ANY that apply and provide explanation:

Yes ☐ No ☐	No Contact Order / or Injunction?
Yes ☐ No ☐	Violent Criminal History?
Yes ☐ No ☐	Mental Health Concerns?
Yes ☐ No ☐	History of Physical/ Verbal Aggression?
Yes ☐ No ☐	Concerns about Substance Abuse?
Yes ☐ No ☐	Does this case have any allegations related to sexual abuse? (Please note, our program cannot accept any cases with Sexual Abuse Allegations)
Explanation:	

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FAMILY VISITATION CENTER REFERRAL

(Please complete this form even if transportation is not being requested.)

Placement Information:

Child	Caregiver	Relationship	Address	Phone Number

Demographic Information:

Child	DOB	SS#	Sex	Race

Visitor	DOB	SS#	Sex	Race	Address	Phone Number

Any history of conflict between Visitors and Caregivers?	Yes ☐ No ☐ Explanation:
Is a Monitored Exchange Required?	Yes ☐ No ☐

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FAMILY VISITATION CENTER - VISITATION PLAN

Case Name: ________________________________ Case Manager ________________________

ONLY PEOPLE LISTED WILL BE ALLOWED TO VISIT UNLESS PRIOR APPROVAL IS OBTAINED THROUGH THE CASE MANAGER, AND THE CASE MANAGER HAS CONFIRMED WITH THE VISITATION TEAM PRIOR TO THE VISIT
(Please include children who will be accompanying adults to visit.)

PRIMARY VISITOR: ___________________________

OTHERS ALLOWED TO VISIT	RELATIONSHIP (to child/ ren)
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

NOTE: IF ANY ADJUSTMENTS NEED TO BE MADE, FAMILY CASE MANAGER MUST CONTACT THE VISITATION CENTER.

__________________________________ __________
Family Case Manager Signature Date

Please submit this Referral with a copy of the Shelter Order to: chs.visitationCFL@chsfl.org
(Please Note: A Referral cannot be accepted and processing cannot begin without a Shelter Order)

***For OFFICE Use Only: Please Leave Blank. ***

FAMILY VISITATION CENTER - VISITATION PLAN

Visits Ordered to be Video Taped Yes ☐ No ☐ This case has an active No Contact Order / Injunction Yes ☐ No ☐ Visitation Services Approved for Community? Yes ☐ No ☐	Who is responsible for Transportation? ☐ Visitation Team ☐ Other: ________	Date Referral Received: Referral Received by: Referral was processed in: _____ Days

Date of Initial Visit	Visit Begin Time	Visit End Time	Scheduled Day/s of the Week	Frequency

_________________________ _________ _________________________ _________
Visitor Signature Date Visitor Signature Date

__________________________________ _________
Family Support Worker Signature Date