Nexus-Kindred
FAMILY HEALING

VISITATION PROGRAM COUNTY REFERRAL

Case Name: _____ Date of Referral: _____

Social Worker: _____ Phone Number: _____

County: _____ County Address: _____

E-mail Address: _____

Guardian ad Litem: _____ Phone Number: _____

E-mail Address: _____

Mother's Name _____ Phone Number: _____

Address: _____

E-mail Address: _____

Father's Name _____ Phone Number: _____

Address: _____

E-mail Address: _____

Children	Date of Birth	Race	Gender

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_____ _____ _____ _____

Day(s) of Visit:

_____

Time of Visit:

_____

Duration of Visit:

_____

Visiting Person(s):

- ☐ Mother
- ☐ Father
- ☐ Other Family: _____
- ☐ Other Friends: _____

Person Transporting Children: _____

Address: _____

Phone: _____

Foster Parent/Guardian: _____

Address: _____

Phone: _____

Other professionals allowed to observe/participate in the visits:

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_____

May the family go off site: ☐ Yes ☐ No

If yes, where: _____

Can photographs be taken during the visit: ☐ Yes ☐ No

Is video recording allowed during the visit: ☐ Yes ☐ No

Is phone use allowed during the visit: ☐ Yes ☐ No

Any restrictions or safety concerns:

_____

Cultural considerations and/or special accommodations:

_____

Specific areas to pay attention to:

_____

Requesting Observation ☐ Yes ☐ No

Requesting Parent Coaching w/ Observation ☐ Yes ☐ No

Requesting Parent Coaching w/o Observation ☐ Yes ☐ No

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Requesting Virtual Visitation ☐ Yes ☐ No

Requesting Transportation ☐ Yes ☐ No

Please allow five (5) business days from the time the referral is received by Kindred for visits to be scheduled.

I authorize Nexus-Kindred Family Healing to conduct visitation services as indicated on the referral form.

Signature: _____ Date: _____

Title: _____

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