FAIR SHAKE, LLC

VISITATION REFERRAL

(please email this form to: referrals@fsvisitsupport.com)

____ Newport

442 Moosehead Trail
Newport, Maine 04953

207-368-6165/Cell 207-341-3407

_____ Lewiston

59 East Ave
Lewiston, Maine 04240

207-333- 5104/Cell 207-341-5581

Please note: If either Wayne Doane or Wendy Hatch is currently the guardian ad litem for a child involved with this referral that child may NOT be referred to Fair Shake for visitation.

Case ID Number: _____District # _____

A. Visiting Child(ren)

Name:_____Gender:_____Age:_____

Name:_____Gender:_____Age:_____

Name:_____Gender:_____Age:_____

Name:_____Gender:_____Age:_____

B. Name of visiting parent(s):

Name:_____Phone Number:_____Relation: _____

Name:_____Phone Number:_____Relation: _____

C. Frequency of visits and preferred days/times:

Open: Monday through Saturday 7:30am-7:00pm and Sunday 7:30 -5.

Length of visitation: _____

First Choice: _____

Second Choice: _____

Whose preferred days and times are these?

D. Who will be transporting the child(ren) to the visit?

Name:_____Phone Number:_____Relation:_____

Name:_____Phone Number:_____Relation:_____

E. Placement information for each child

Name:_____Phone Number:_____Relation:_____

Name:_____Phone Number:_____Relation:_____

Name:_____Phone Number:_____Relation:_____

F. Is the visiting parent permitted to support transition to and from the vehicle of the person transporting the child(ren), including buckling the child(ren)?

_yes/no__

G. Does the staff need to accompany the child to the bathroom?

_yes/no__

Are visiting parents allowed to accompany the child to the bathroom?

_yes/no__

H. Does staff need to accompany the transporting person and child(ren) to or from the vehicle?

_yes/no__

I. Is there a PFA between visiting parents? Is there a need to have visits on separate days for the child(ren)'s parents?

_yes/no__

J. Specify circumstances which will result in the termination of the visit:

If visit is terminated who is to be contact to pick the children up early?

Name:_____Phone Number:_____Relation:_____

K. Do the parents have a history of verbal or physical aggression? _yes/no__

L. Does the child(ren) have any special medical needs/medications and/ or allergies?

M. Is the parent permitted to administer medication if needed?

_yes/no___

N. Level of supervision:

0. Are there others who can attend the visit? If so, how many times are they allowed at a visit, and the names of people who are allowed.

Name:_____Relation:_____Frequency_____

Name:_____Relation:_____Frequency_____

Name:_____Relation:_____Frequency_____

P. Who is permitted access to the live stream of the visit? (name and email address)

Name: _____ Email: _____

Contact Number: _____

Name: _____ Email: _____

Contact Number: _____

Name: _____ Email: _____

Contact Number: _____

Q. DHHS caseworker who will receive the visit video (name and Email), Please include any lawyers that need copies of the video:

Name: _____ Email: _____

Contact Number: _____

Caseworker Supervisor name: _____ Email: _____

Contact number: _____

Name: _____ Email: _____

Contact Number: _____

Name: _____ Email: _____

Contact Number: _____

R. Immediate Risk Statement: Special Circumstances: