DENISIQI CHILD AND YOUTH COUNSELLING

REFERRAL FORM

Client Name:			**Age:**
Date of Birth:	**Gender:**		**City/Town:**
Address:			**Postal Code:**
Client Home Phone:		**Client Cell Phone:**	
Status: Yes ☐ No ☐ **Affiliated Band:** **Metis: Yes ☐ No ☐**	**Urban ☐** **Rural ☐**	**School name:** **Current grade:**	

Name of Parent(s)/Legal Guardian(s)/Caregiver(s):

1) Name: _____ Home Phone: _____ Cell Phone: _____
2) Name: _____ Home Phone: _____ Cell Phone: _____
3) Name: _____ Home Phone: _____ Cell Phone: _____

Family Doctor's Name: **Current Medications:**	**Has child/youth had previous counselling services? Yes☐ No ☐ (if yes, when/with who?)**

Any other Community Supports: (school counsellor, CDC, social worker, Outreach worker?) Yes☐ No ☐

What is the concern you have for your child/youth/family?

Anxiety		**Eating Disorder**		**Behaviour Problem**		**Aggression**		**Abuse**	
Depression		**Substance Abuse**		**Voices/Hallucinations**		**Trauma**		**Self-Harm**	

Additional Comments:

Risk for Suicide a concern today?: Yes☐ No ☐ **Others safety concerns today?: Yes☐ No ☐**	**Other (describe):**	**Is Client Aware of this Referral?** **Yes ☐** **No ☐**	**Urgent?** **Yes ☐** **No ☐**

Referral Date:	**Referral Source Organization:**
Referral Source Name (Print):	**Referral Source Signature:**

FAX FORM TO: Cindi Saj @ 250.392-6501
Any questions? Call 250.392-6500