Chilliwack Community Services
SHARE·GROW·BELONG

45938 Wellington Ave
Chilliwack, BC V2P2C7

tel: 604.792.4267
fax: 604.792.6575

email: ccsinfo@comserv.bc.ca
website: www.comserv.bc.ca

FAMILY SERVICES REFERRAL FORM

TYPE OF REFERRAL AND GOALS

(choose a therapy service OR a group service)**:**

THERAPY SERVICES:	**Description:**
☐ **Family Therapy w/FSW**	Outreach family therapy for MCFD/FVACFSS open child protection files.
☐ **Youth Family Therapy**	Outreach individual youth counselling or with family.
☐ **Early Years Therapy**	Outreach family therapy for families with children 6 and under.
☐ **SAIP**	Sexual Abuse Intervention Program – for children involved in suspected sexual abuse.
☐ **In-Office Therapy**	Therapy delivered by CCS's Master's level counselling interns.
GOALS FOR SERVICE **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, **T**imely	
Therapeutic Goals:	
Family Support Goals If Applicable: *(only applicable for MCFD/FVACFSS referrals)*	
Send Therapy Referral to:	Anja Vogels, Clinical Coordinator Subject: Therapy referral Email: vogelsa@comserv.bc.ca Phone: 604-793-7215 | Cell: 604-798 -5105 | Fax: 604-792-6575

FAMILY EDUCATION GROUP REFERRAL:	Monthly Group Schedules at **http://comserv.bc.ca/family-education**
☐ **Family Building** – Monthly Entry (i.e. parenting and family relationships, anger / emotional regulation, discipline)	
☐ **Attachment Building** – Quarterly Entry (Circle of Security)	
☐ **DARING Dads (Daring, Authentic, Respectful, Inviting, Nurturing, Game-changer)** – Continuous Entry (Education and Support)	
☐ **Skills Building** – Continuous Entry (i.e. budgeting, nutrition, health, communication, family routine)	
Referral Worker/Participant Goal: (what your goal is for group?)	
Send Group Referral to: Patricia Hryhorczuk	CCS Family Education Program Subject: Group referral Email: familyeducation@comserv.bc.ca Phone: 604-792-6632 x 111 | Fax: 604-792-6575

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REFERRER INFORMATION:

Date:		*MCFD Referrals Only:* ☐ *Protection* ☐ *Non-protection* ☐ *Open File*	
		FVACFSS Referrals Only: ☐ *Protection* ☐ *Non-protection* ☐ *Open File*	
Referred by:		Email:	
Organization:		Cell phone:	

REFERRAL INFORMATION:

PARENT/GUARDIAN/CAREGIVER:		**PARENT/GUARDIAN/CAREGIVER:**	
First & Last Name:		First & Last Name:	
Relationship:		Relationship:	
DOB:		DOB:	
Cell Phone:		Cell Phone:	
Address:		Address:	

CHILDREN:	**Name**	**Gender**	**Birthdate**	**Identified Client?**
		☐ M ☐ F ☐ OTHER		☐
		☐ M ☐ F ☐ OTHER		☐
		☐ M ☐ F ☐ OTHER		☐
		☐ M ☐ F ☐ OTHER		☐

BACKGROUND INFORMATION:

Reasons for Referral:

Which child(ren)/individual(s) are you most concerned about?

IMPORTANT SOCIAL HISTORY AND CONCERNS:

☐ Cultural issues ☐ Educational/Literacy issues ☐ Employment issues ☐ Housing issues	

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CRITICAL INCIDENT CHECKLIST
☐ Legal Circumstances (probation, no contact order, etc.)
☐ Is there a criminal history we should be aware of for either parent/caregiver or child/teen?
☐ Are there any behaviors we should be aware of? (sexually inappropriate behaviour, etc.)
☐ Safety concerns (domestic violence, hx of violence, aggressive dog, bed bugs, unsafe neighborhood, etc.)
☐ Are there any risks to staff that we need to be aware of? (aka drug use that induces violence, hx of violence against persons, mental instability/illness, patterns of assault, short temper, etc.)

IMPORTANT MEDICAL HISTORY / ISSUES

Please list any language, hearing, visual, physical disabilities, mental illness, medications, etc.

Client Name	Physical Health Info	Mental Health Info	Suspected	Diagnosed
			☐	☐
			☐	☐
			☐	☐
			☐	☐