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 / SUPPORT SERVICES:	**Description:**
☐ **Family Counselling w/Support**	Outreach family counselling, support & resources for *MCFD 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
Specific, **M**easurable, **A**ttainable, **R**ealistic, **T**imely

Goals & Needs (counselling, support, resources):

Send Therapy Referral to:	Esther Gubiotti, Clinical Coordinator Re: Counselling/ Support Referral	Email: gubiottie@comserv.bc.ca Phone: 604-793-7215 | Cell: 604-798 -5105 | Fax: 604-792-6575

OR:

FAMILY EDUCATION TEAM REFERRAL:	Monthly Workshop Schedule at http://comserv.bc.ca/family-education

☐ **Family Building** – Continuous Entry
(i.e. parenting and family relationships, anger and aggression, emotional adaptability, discipline)

☐ **Attachment Building** – Monthly Entry
(Circle of Security)

☐ **DARING Dads (Daring, Authentic, Respectful, Inviting, Nurturing, Game-changer)** – Continuous Entry
(Education and Support)

☐ **Skills Building** – Continuous Entry
(i.e., family routines, family meetings, internet safety, communication,)

Referral Worker/Participant Goals & Needs: (what are the goals is for this Service?)

Send Group Referral to: Steve Dove	CCS Family Education Program Subject: Group referral	Email: familyeducation@comserv.bc.ca Phone: 604-792-6632 ext. 345 | Fax: 604-792-6575

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REFERRER INFORMATION:

Date:		*MCFD 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		☐
		☐ 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, history of violence, aggressive dog, bed bugs, unsafe neighborhood, etc.)

☐ Are there any risks to staff that we need to be aware of? (i.e. drug use that induces violence, history 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
			☐	☐
			☐	☐
			☐	☐
			☐	☐