Chilliwack Community Services
SHARE•GROW•BELONG

# Referral Young Family Program

**Refer to: Kaleigh Roberts**
**Youth Services Coordinator**
604 702 2903
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Fax: 604 792 6575

**CLIENT INFORMATION**

| | | | |
|---|---|---|---|
| Name: | | | |
| Phone: | | Birthdate: | |
| Address: | | ☐ Foster Home ☐ Group Home<br>☐ Parent/Relative Home ☐ Homeless<br>☐ Couch Surfing/Shelter ☐ Other: | |
| Children: | Name | Birth Date (or Expected) | Location of Children |
| | | | |
| | | | |
| | | | |

**REFERRAL INFORMATION**

| | |
|---|---|
| Referred By: | Referral Date: |
| Organization: | Contact (ph/email): |

**MCFD/FVACFSS or JUSTICE INFORMATION:**

| | | |
|---|---|---|
| Worker: | | Phone: |
| Email: | Type of Agreement: | |
| MCFD File: ☐ Open ☐ Closed | FVACFSS File: ☐ Open ☐ Closed | ☐ None |
| Any no contact orders: | | |
| Probation Information: | | |

**REASONS FOR REFERRAL**

(Include relevant background information, pregnancy information, family background, presenting issues/risk factors i.e. mental health, addictions, cultural issues, etc.)

**CAREGIVER INFORMATION**

| Parent/Guardian: | Phone: |
|---|---|
| Address: | |

Parent/caregiver aware of referral? Yes ☐ No ☐
Youth willing to engage in services? Yes ☐ No ☐

**SCHOOL STATUS:** ☐ Not Attending School ☐ Attending School

| School and Grade: | |
|---|---|
| Relevant Information: | |

**MENTAL HEALTH/PHYSICAL HEALTH CONCERNS:**

| Mental or Physical Health Information (include Mom, Baby, and Children) | Suspected (Y/N) | Diagnosed (Y/N) | Medications |
|---|---|---|---|
| | Yes | Yes | |
| | Yes | Yes | |
| | Yes | Yes | |
| Prenatal/Perinatal Support: Yes ☐ No ☐ | Program: | | |
| Doctor / Nurse Practitioner: | | | |

**SUICIDE RISK ASSESSMENT** (When applicable)

| HIGH ☐ | MEDIUM ☐ | LOW ☐ |
|---|---|---|
| Suicide intent with plan/means and a history. Has no perceived supports | Indicated suicide intent<br>May have plan and limited supports | Suicide ideation<br>Does not have clear plan and has supports |

☐ None

**CLIENT HISTORY:**

| | | | |
|---|---|---|---|
| ☐ Drug Use ☐ Suspected or Confirmed ☐ | How Often: | Drug(s) of Choice: | |
| ☐ Alcohol Use ☐ Suspected or Confirmed ☐ | How Often: | | |
| ☐ History of Violence | ☐ Criminal Activity | ☐ Sexual Exploitation | ☐ Engages in High Risk Behaviors |
| ☐ Family Trauma | ☐ Exposure to Domestic Violence | ☐ Caregiver Addiction | ☐ Other |
| Safety Concerns: | | | |

**GOALS OF SERVICE REQUESTED** (Related to reasons for referral)

| | |
|---|---|
| 1. | |
| 2. | |
| 3. | |