COMMUNITY SERVICES - REFERRAL FORM

Agassiz-Harrison Community Services Society
7086 Cheam Ave, P.O Box 564
Agassiz, B.C, V0M 1A0
Ph: 604-796-2585 Fax: 604-796-2517

- ☐ Family Therapy
- ☐ Family Support Worker
- ☐ Substance Use Counsellor
- ☐ Youth Outreach Worker
- ☐ Youth Justice Worker
- ☐ Youth Suicide Worker

Referred by:	Organization:	Date:
Phone:	Email:	

CLIENT INFORMATION:

Last Name:	First Name:	Birthdate:	Age:
Address:		Phone #:	
City:	Postal Code:	Cell #:	

CONSENTS REQUIRED	**ANSWER YES, OR NO?**
Request for services without parental involvement for children under the age of 19: Is the child a mature minor? Does child sufficiently understand the nature of the counselling they are agreeing to and have a reasonable grasp of its probable consequences?	
Can a support person call the phone numbers provided?	
Can a support person leave a message/voicemail at the phone numbers provided?	

PARENT OR GUARDIAN INFORMATION:

Last Name:	First Name:	Phone #:

CHILDREN:

Last Name	First Name	Gender	Birthdate	Age

Location of Child(ren):	Relationship of Caregiver to Child(ren):
Which child(ren) are you most concerned about?	

REASON FOR REFERRAL/GOALS OF SERVICE REQUESTED:

CRITICAL INFORMATION: (safety concerns, MCFD involvement, legal circumstances)

IMPORTANT MEDICAL HISTORY/CONCERNS:

Physical health Information *Any language, hearing, visual, physical disabilities, etc.*	Mental Health Information *Any suspected or diagnosis or prescribed medication*

PREVIOUS PROGRAM INFORMATION (Counselling, Youth Justice, Anger Management, etc.) - **TO BE COMPLETED BY REFERRING SOURCE**

Program/Resource	From When to When:	Contact Person	Phone #