



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

- | | |
|---|--|
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Youth Outreach Worker |
| <input type="checkbox"/> Family Support Worker | <input type="checkbox"/> Youth Justice Worker |
| <input type="checkbox"/> Substance Use Counsellor | <input type="checkbox"/> 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	
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 <i>Any language, hearing, visual, physical disabilities, etc.</i>			Mental Health Information <i>Any suspected or diagnosis or prescribed medication</i>		
PREVIOUS PROGRAM INFORMATION (Counselling, Youth Justice, Anger Management, etc.) - TO BE COMPLETED BY REFERRING SOURCE					
Program/Resource		From When to When:		Contact Person	
				Phone #	