

**PARENT SUPPORT PROGRAM REFERRAL FORM**

DATE OF REFERRAL: \_\_\_\_\_  
MONTH DAY YEAR

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_  
DOB: \_\_\_\_\_ Is this a First Nations or Metis client?  yes  no  
MONTH DAY YEAR  
Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Custody Info:  2  SP/mom  SP/dad  Co-parents  Child in care Income Assistance:  yes  no  
Partner's Name: \_\_\_\_\_ Language Spoken at Home: \_\_\_\_\_  
Children: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
MONTH DAY YEAR  
\_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Others in the home: \_\_\_\_\_  
Previous Cameray involvement?  yes  no Program and dates: \_\_\_\_\_

Source of Referral: \_\_\_\_\_ Phone: \_\_\_\_\_  
Position: \_\_\_\_\_ Has family given consent to contact us?  yes  no

Newborn?  yes  no If yes, Public Health visit within 2 weeks of referral?  yes  no

Background Information / Comments / Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: (Please provide details.) Medication:  yes \_\_\_\_\_  no  
MCFD involvement:  yes Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_  
Mental Health involvement: \_\_\_\_\_  
Suicidality: \_\_\_\_\_  
Substance abuse: \_\_\_\_\_  
Other referrals made: \_\_\_\_\_

Intake by: \_\_\_\_\_ Referral No: \_\_\_\_\_ Entered on Computer:  By: \_\_\_\_\_  
Does referral fit program criteria?  yes  no Approved by Co-ordinator: \_\_\_\_\_  
Date File Opened: \_\_\_\_\_ Counsellor Assigned: \_\_\_\_\_