Cameray
Child & Family Services

EARLY YEARS PARENTING SUPPORT PROGRAM - REFERRAL FORM

DATE _____ **2023**
MONTH DAY YEAR

Client Name:		Age:	Phone:
DOB: _____ MONTH	DAY	YEAR	Is this a First Nations or Métis client? ☐ Yes ☐ No
Address:		City: SELECT CITY	Postal Code:
Email:			Permission to use Email? ☐ Yes ☐ No
Custody Info: ☐ 2 Parent ☐ SP/mom ☐ SP/dad ☐ Child in Care			Income Assistance? ☐ Yes ☐ No
Partner's Name:			Language Spoken at Home:
Children:	Gender:	Age:	DOB: _____ MONTH DAY YEAR
	Gender:	Age:	DOB: _____ MONTH DAY YEAR
	Gender:	Age:	DOB: _____ MONTH DAY YEAR
Others in the home:			
Previous Cameray involvement? ☐ Yes ☐ No		Program & Dates:	

Source of Referral: ☐ SELF	Phone:
Position/Organization:	
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: ☐ Groups Only ☐ One to One: ☐ *virtual* ☐ *in person*

Other: *(Please Provide Details)* Medication:	☐ Yes	☐ No
MCFD Involvement: ☐ Yes	Social Worker:	Phone:
Mental Health Involvement:		
Suicidality:		
Substance abuse:		
Other referrals made:		

OFFICE USE ONLY

Referral taken by: _____ ☐ *On computer*

Intake Counsellor: _____ *Approved by:* ☐ _____

Date File Opened: _____ *Counsellor Assigned:* _____

Referral No: _____ *Closing Date:* _____ ☐ *NCM*

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