Family & Youth Support Services
630 - 2nd Avenue, PO Box 1653
Ladysmith, BC V9G 1B2
Phone: 250-245-3079
Fax: 250-245-3798

LADYSMITH RESOURCES CENTRE ASSOCIATION
Heart on the Hill

REFERRAL FORM

Referral Date: _____

Referred to: ☐ Family Support Worker (6-12yr) ☐ Youth Worker (13-18yr)

Primary Client Name: _____ Gender: ☐ - Male ☐ - Female

Child's/Youth's Date of Birth: _____ Ethnicity: _____

Address: _____

Name of Guardian: _____

Name of Mother: _____ In home? ☐ YES ☐ NO

Name of Father: _____ In home? ☐ YES ☐ NO

Sibling(s)/Age: _____ In home? ☐ YES ☐ NO

Home Phone: _____ Alternate: (work/cell): _____

Emergency Contact: _____ Phone: _____

Referred by: _____ Relationship to client: _____

Phone: _____

Reason for referral: _____

_____

_____

_____

_____

For MCFD use only

Referral Source:
- ☐ Family Services / Child Protection
- ☐ Child and Youth Mental Health
- ☐ Youth Services
- ☐ Guardianship
- ☐ Other: _____

MCFD Status: ☐ None ☐ Interim Order ☐ TCO ☐ CCO ☐ OTHER _____

Is there an integrated case management team in place?	☐ YES ☐ NO
Are the other team members (professionals, caregivers etc.) aware of this referral?	☐ YES ☐ NO
Has the child/youth been informed of this referral?	☐ YES ☐ NO
Is the child/youth open to receiving service?	☐ YES ☐ NO

General Information and background of client: _____

_____

_____

Risk to Worker: □ No □ Yes, Specify: _____

Risk factors: _____

_____

Goals for Service: _____

_____

_____

_____

Other Involved Professionals:

Name	Role/Relationship	Phone/Email

FOR FAMILY SUPPORT REFERRALS ONLY: As LRCA Family & Youth Support Services programs are funded by the Ministry of Children and Family Development, information about your family and this referral may be shared with representatives of MCFD and other professionals on the Family Support Screening Committee. By signing below you are giving consent for information to be shared solely for the purposes of admittance into the program. Any additional sharing of information will require a separate release of information form to be signed by the client.

Client Signature: _____

FOR LRCA STAFF USE ONLY:

If Family Support referral, date referral received by SCREENING COMMITTEE: _____

☐ Screened In (Immediate Service) ☐ Screened In (Waitlisted) ☐ Screened out

If Screened Out - Reason(s): _____

_____

Date placed on Waitlist (if necessary):_____

Date of contact with referral source: _____

Date of Admission in to Program: _____

Date contact made with client: _____

Additional notes: _____

_____