LRCA 630 - 2nd Avenue
Ladysmith, BC V9G 1B2
Phone: 250-245-3079

LADYSMITH RESOURCES CENTRE ASSOCIATION
We Help Build Our Thriving Community

Family & Youth Support Services Program

Fax: (250) 245-3798

REFERRAL FORM

Referral Date: ads

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

Primary Client Name: ads

Gender: ads Other: asd

Client Birthdate : ads Age: ads

Ethnicity/Cultural Background: asd School/Grade: asd

Address: asdasdasd

Name of Guardian/Caregiver(s): ads

Name of Mother: ads In home? ○ YES ◉ NO

Name of Father: ads In home? ○ YES ◉ NO

Sibling(s)/Age: In home? ○ YES ◉ NO

Main Phone(s): Alternate(work/cell): asd

Emergency Contact: Phone: asd

Referred by: ads

Relationship to client: asd

Phone: adsad Email: ads

Report required: ○ YES ◉ NO

Reason for referral:

_____

_____

_____

_____

_____

General information and background of client:

asd

asd

Risk to Worker: ◯ No ◯ Yes Risk factors:

adad

Goals for Service:

☑ **Social recreation** ☑ **social skills** ☑ **parent/family support** ☐ **groups** ☑ **other**

For MCFD use only

Referral Source:
- ☑ Family Services / Child Protection
- ☑ Delegated Aboriginal Agency
- ☑ CYSN
- ☑ Child & Youth Mental Health
- ☑ Indigenous CYMH
- ☑ Youth Services
- ☑ Guardianship
- ☐ Other: adasdad

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

Other Involved Professionals:

Name	Role/Relationship	Phone/Email
ads	asd	ad
ad	ad	asd
asd	asd	ada
asd	ad	d

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:

Date referral is received by FYSS SCREENING COMMITTEE:

asd

◯ Screened In (Immediate Service) ◯ Screened In (Waitlisted) ◉ Screened out

If Screened Out - Reason(s): asd

asd

asd

Date placed on Waitlist (if necessary): ad

Date of contact with referral source: asd

Date of Admission in to Program: asd

Date contact made with client: asd

Additional notes:

- asd
- asd
- asd