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Ladysmith, BC V9G 1B2
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LADYSMITH RESOURCES CENTRE ASSOCIATION

We Help Build Our Thriving Community

Referral Form - Family & Youth Support Services Program

Referral Date: ____

Referred for: ☐ Child / Family Support *(ages 6-12yr)* ☐ Youth Support *(ages 13-18yr)*

Client (Child/Youth) Name: ____

Gender: _________________________ Pronouns:____________________ Other: ___________________

Client Birthdate:__________________________________Age: ______________________________

Ethnicity/Cultural Background: ______________________School / Grade: ___________________________

Home Address: ____

Guardian/Primary Caregiver(s) Name(s) :____

Name of Mother:____In home? ☐ YES ☐ NO

Name of Father: ____In home? ☐ YES ☐ NO

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

Caregiver/Guardian Phone(s): ________________________Alternate: _________________________

Youth Cell Phone:___________________________________Texting ☐ YES ☐ NO Calling ☐ YES ☐ NO

Emergency Contact:________________________________ Phone: ________________________________

Referred Source (Professional): ____

Relationship to client: ____

Phone: ______________________________Email: ____

Reports Required: ☐ YES ☐ NO

Reason for Referral – Please share what you need or want support with most, what brings you here?

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CONFIDENTIAL INFORMATION

Other helpful information and/or background of client:

____

____

Risk to Worker: □ No □ Yes Risk factors: ____

Goals / Hopes for Support: ____

◯ **Recreation /Community** ◯ **Social/Emotional** ◯ **Parent/Family Support** ◯ **Groups** ◯ **Resourcing**

Goal 1:

____

Goal 2:

____

Goal 3:

____

For MCFD use only

Referral Source:
- ☐ Family Services / Child Protection ☐ Delegated Aboriginal Agency
- ☐ Children and Youth with Support Needs (CYSN)
- ☐ Child & Youth Mental Health (CYMH) ☐ Indigenous CYMH
- ☐ 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

Other Involved Professionals – Collaborations to Consider:

Name	Role/Relationship	Phone/Email Contact Information

As LRCA Family & Youth Support Services programs are funded by the Ministry of Children and Family Development(MCFD), information about your family and this referral may be shared with representatives of MCFD and other professionals on the 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:____ **Date:**____________________

FOR LRCA STAFF USE ONLY:

Date referral is received by FYSS 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:

- ____
- ____
- ____
- ____
- ____
- ____

CONFIDENTIAL INFORMATION