Fraser Valley Aboriginal Children and Family Services Society

**\*Please fill both pages and send referral electronically to:** StoLoTherapy@xyolhemeylh.bc.ca

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| **REFERRAL SOURCE** |
| Date of Referral:  | Referred by:  |
| Agency Name: Xyolhemeylh (Fraser Valley Aboriginal Children and Family Services Society) |
| Contact Info: Email Address: Phone #: |

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|  | **CAREGIVER INFORMATION** |
| Last Name:  | First Name: |  |
| Address:  | City:  | B.C. | Postal Code: |
| First Nation:  |  | Name of Community: |
| Phone #:  |  | Email Address:  |
| Parent  | Stepparent  | Foster Parent  | EFP Caregiver  |  |

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| **CHILD/YOUTH/PERSON BEING REFERRED** |
| Last Name:  | First Name: | Date of Birth:  |
| First Nation:  | Name of Community:  |
| Phone #:  | Email Address:  |

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| **FURTHER QUESTIONS** |
| Is the client consenting to referral? | Yes  | No  |
| Is the client in school? | Yes  | No  | If the client is in school, what is the name of the school? |  |
| Is there a police file open? | Yes | No | When was the report made?What is the file number?Who is responsible for the file (Name)? |  |
| Is there a child safety file open? | Yes  | No | When was the file opened?Who is the worker responsible for the file? |  |

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| **REASON FOR REFERRAL (Please be concise)** |
| **1.Presenting issue(s):** **2.Your Hopes & Goals for Service:**  |

**3. Please indicate if there is current involvement with C&YMH, or other Mental Health Professionals: Who and how long?**