Cariboo Family Enrichment Centre

"Strengthening the quality of personal, family, and community life"

CONFIDENTIAL

External Referral Form

Referring Social Worker/Agency/Organization: _____

Requested Service:	
❑ Anger Management	❑ Home Visitor: Early Years Service
❑ Child Care Resource & Referral/Subsidy	❑ ICM Facilitation
❑ Communication Tools	❑ Parent-Teen Mediation
❑ Counselling Services	❑ Parenting Education
❑ Early Care and Learning Centre (Daycare)	❑ Prenatal/Pregnancy Outreach
❑ Early Years Screening	❑ Relationship Counselling
❑ Family Case Planning Conference	❑ Supported/Supervised Visits
❑ Family Group Conference	❑ Youth Agreement
❑ Family Mediation	❑ Youth Employment Services
❑ Family Support Worker	❑ Youth Outreach
❑ FASD/CDBC	❑ Youth Transition

Date of Authorization for Service: _____ **Review Date:** _____

Parent or Guardian's Name:	❑Mr. ❑Mrs. ❑Ms. _____ ❑Birth Parent ❑Stepparent ❑Grandparent ❑Other (please specify) : _____
Parent or Guardian's Name:	❑Mr. ❑Mrs. ❑Ms. _____ ❑Birth Parent ❑Stepparent ❑Grandparent ❑Other (please specify) : _____

Mailing Address: _____

Physical Address: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Name of Child(ren)	Male/Female	Date of Birth	Age	Child In Care/Caregiver's Name
				❑No ❑Yes/Name:
				❑No ❑Yes/Name:
				❑No ❑Yes/Name:
				❑No ❑Yes/Name:
Caregiver's Contact Information:	Home Phone : _____ Work Phone : _____ Cell Phone : _____ Physical Address: _____ Mailing Address : _____			

P.O. Box 2427, #1 -486 Birch Avenue, 100 Mile House, B.C. V0K 2E0
Telephone: (250) 395-5155 Fax: (250) 395-1811

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Reports Requested: ❑ Yes ❑ No

Are there child protection concerns? ❑ Yes ❑ No

If yes, please explain:

Are there safety concerns? ❑ Yes ❑ No

If yes, please explain:

Brief description of situation:

Family/Child/Youth/Client strengths:

Goals/outcomes set for the service requested:

MANDATORY:

I have read this form and had the opportunity to ask questions, and I agree to this referral.

Signature of Parent/Guardian	Print Name	Date	
Signature of Child/Youth/Adult client	Print Name	Date	
Signature of Social Worker/Clinician/Referral Service	Print Name	Date	Team Leader Initial

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