NARSF
PROGRAMS LTD.

201-170 WALLACE STREET
NANAIMO, BC V9R 5B1
PH: (250) 754-2773
FAX: (250) 754-1605

COMMUNITY/SELF REFERRAL FORM (2020)

Program referred to: ☐ **ED** - EATING DISORDERS PROGRAM ☐ **SAIP**- SEXUAL ABUSE INTERVENTION PROGRAM
☐ **LIFT**-LIVING IN FAMILIES WITH TEENS

Date of Referral: _____ (dd/mm/yy) Referred by: _____

Team: _____

Phone: _____ Fax: _____

1. Name(s) of Person/Family being referred: _____ Birth Date: _____ (dd/mm/yy)

Address: _____ Gender: ☐F ☐M ☐Non-Binary

Hm. Phone: _____ Alt. Phone: _____ Special Precautions: Y☐ N ☐

Status: ☐Parent ☐Step Parent ☐Foster Parent ☐Child/Youth ☐Child in Care ☐Other: _____

Legal Status: ☐Legal Guardian ☐Full Custody ☐Shared Custody ☐Supervised Visitation ☐Not Applicable

If applicable: Type of upcoming legal process: _____ Estimated date: _____ (dd/mm/yy)

Emergency Contact Name: _____ Phone: _____

Relation to Person being referred: _____

2. Name(s) of Person/Family being referred: _____ Birth Date: _____ (dd/mm/yy)

Address: _____ Gender: ☐F ☐M ☐Non-Binary

Hm. Phone: _____ Alt. Phone: _____ Special Precautions: Y☐ N ☐

Status: ☐Parent ☐Step Parent ☐Foster Parent ☐Child/Youth ☐Child in Care ☐Other: _____

Legal Status: ☐Legal Guardian ☐Full Custody ☐Shared Custody ☐Supervised Visitation ☐Not Applicable

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Significant Others:

Name:	Role/Relationship:	Phone:	Date of Birth if < 19:

Other Professionals Involved:

Name:	Role/Relationship:	Phone/Fax:

Reason for Referral:

Additional Information:

Goals for Referral:

General Risk Factors for Referred Person(s):

Potential Risk to NARSF Staff (e.g. Health/medical concerns, personal safety concerns, history of violence)**:**

Signatures: Please sign below to indicate that this referral has been reviewed by both the referring worker and the person being referred.

Signature of Person(s) being referred — Date: dd/mm/yy

Signature of Referring Person and area team code if applicable — Date: dd/mm/yy