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| **NARSF: COMMUNITY-BASED REFERRAL** | Program referred to:[ ]  **EDP** - Eating Disorders Program[ ]  **SAIP** - Sexual Abuse Intervention Program[ ]  **LIFT** - Living in Families with Teens |
| Please fax signed and completed referrals to: 250-754-1605.Please do not email. |
| Date of Referral: |  | Referred by: |   |
|  | (dd/mm/yy) | Team: |   |
|  |  | Phone: |   | Fax: |   |
| **1. Name(s) of CHILD/YOUTH:** |   | Birth Date: |   |
|  |  | (dd/mm/yy) |
| Address: |   | Gender: | [ ] F [ ] M [ ] Non-Binary |
| Main Phone: |   | Alt. Phone: |   | Special Precautions: Y[ ]  N [ ]  |
| If applicable - type of upcoming legal process: |   | Estimated date:  |   |
|  | (dd/mm/yy) |
| **2. Name(s) of CAREGIVER:** |   |
| **Relationship to child/youth:** |  |
| Address: |   | Gender: | [ ] F [ ] M [ ] Non-Binary |
| Main Phone: |   | Alt. Phone: |   |  |
| **3. Significant Others/Family Members involved in referral:** |
| Name: | Role/Relationship: | Phone: | Date of Birth if < 19: |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

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| **4. Other Professionals Involved:** |
| Name: | Role/Relationship: | Phone/Fax: |
|   |   |   |
|   |   |   |
|   |   |   |
| **5. Reason for Referral:** | **6. Goals for Referral:** |
|   | **i.**   |
| **ii.**  |
| **iii.**  |
| **7. General Risk Factors for Referred Person(s):**  Please detail current/past safety concerns (i.e. suicide, self-harm, violence towards others, or risky behaviours). If yes, is there a safety plan? Y☐ N ☐  |
| **8. Potential Risk to NARSF Staff:** Please detail any health/medical concerns, safety concerns, history of violence, etc., if applicable.  |
| **9. Additional Information:**  Please detail any additional information that may impact the referral, if applicable.  |
| **10. Verification & Consent:** Please ensure the referral is complete, correct and that the person referred is aware of the referral, and if possible, has provided consent.Consent for referral provided by person(s) being referred: Y[ ]  N [ ]  |
|   | Date: |   |
| Signature of person(s) being referred or indicate verbal consent |  | dd/mm/yy |
|   | Date: |   |
| Signature of referring person |  | dd/mm/yy |
| Please fax signed and completed referrals to: 250-754-1605 |