NARSF PROGRAMS LTD

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

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: _____ (dd/mm/yy) Referred by: _____

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:

Continued on next page

…

NARSF PROGRAMS LTD

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

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 ☐

Signature of person(s) being referred or indicate verbal consent

Date: dd/mm/yy

Signature of referring person

Date: dd/mm/yy

Please fax signed and completed referrals to: 250-754-1605