NARSF PROGRAMS LTD

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

# TRANSITIONS PROGRAM REFERRAL

Service Requested:

☐ Withdrawal Management (7-10 days)

☐ Supportive Recovery (up to 3 months)

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

Team/Org/Agency or Self: ______________________

Phone: ____________ Fax: ____________ Email: ____________

## 1. Youth & Family Information:

Youth Name: ______________________ Birth Date: ____________ (dd/mm/yy) Age: ______

Gender: ☐F ☐M ☐Non-Binary ☐Other: ____________ PHN: ____________

Address: ______________________

Main Phone: ____________ Alt. Phone: ____________

Caregiver: ____________ Relationship: ____________

Phone: ____________ Email: ____________

## 2. Other Professionals Involved:

| Name: | Role/Relationship: | Phone/Fax: |
|---|---|---|
| | | |
| | | |
| | | |

## 3. Substance Use: Please describe past or current substance use. Current substance use? Y☐ N ☐

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**4. Presenting Concerns:**

Please identify client strengths/resiliencies that will assist with success in the program.

**i.**

**ii.**

**iii.**

**5. Risk Factors & Safety Concerns:**

If present, please describe:

☐ Mental health considerations
☐ Suicidal ideations
☐ Self-harm
☐ Significant medical needs
☐ Legal issues
☐ Violence/aggression
☐ AWOL/flight risk

If risk factors are present, is there a safety plan? Y ☐ N ☐

Follow up date: ______________ (dd/mm/yy) Staff: ____________________

**6. Additional Information:** Please detail any additional information that may impact the referral, if applicable.

**7. 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
Please do not email.