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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 | | | | | |