Fraser Valley Aboriginal Children and Family Services Society

SAIP Referral Form

**\*Please send referral electronically to:** SAIP@xyolhemeylh.bc.ca

|  |
| --- |
| **REFERRAL SOURCE** |
| Date of Referral:  | Referred by:  |
| Agency Name: Fraser Valley Aboriginal Children and Family Services Society  |
| Contact Info: Email Address: Phone #: |

|  |
| --- |
| **CAREGIVER INFORMATION** |
| Last Name:  | First Name:  |
| Address:  | City:  | Postal Code: |
| First Nation:  | Name of Community:  |
| Phone #:  | Email Address:  |
| Parent  | Step Parent | Foster Parent | EFP Caregiver | Child/Youth |

|  |
| --- |
| **CHILD/YOUTH BEING REFERRED** |
| Last Name:  | First Name: | Date of Birth:  |
| First Nation:  | Name of Community:  |
| Phone #:  | Email Address:  |

|  |
| --- |
| **FURTHER QUESTIONS** |
| Is the client consenting to referrals? | Yes  | No  |
| Is the client in school? | Yes  | No  | If the client is in school, what is the name of the school? |  |
| Is there a police file open? | Yes | No | When was the report made?What is the file number?Who is responsible for the file? |  |
| Is there a child safety file open? | Yes  | No | When was the file opened?Who is the worker responsible for the file? |  |

|  |
| --- |
| **REASON FOR REFERRAL** |
| **1.Presenting issue(s):** **2.Your Hopes & Goals for Service:**  |

**3. Please indicate if there is current involvement with C&YMH, or other Mental Health Professionals:**