Fraser Valley Aboriginal Children and Family Services Society

***Please fill both pages and send referral electronically to:** Stolotherapy@xyolhemeylh.bc.ca

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

	CAREGIVER INFORMATION			
Last Name:	First Name:			
Address:	City:	B.C.	Postal Code:	
First Nation:		Name of Community:		
Phone #:		Email Address:		
Parent ☐	Stepparent ☐	Foster Parent ☐	EFP Caregiver ☐	

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

FURTHER QUESTIONS					
Is the client consenting to referral?				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 (Name)?		
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 (Please be concise)
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: Who and how long?