Serving the Mt Waddington area
7305 Market Street, Port Hardy
Tel: 250.902.6063
Fax: 250.902.6064

Discovery Youth & Family Substance Use Services

REFERRAL FORM

TODAY'S DATE:	REFERRED BY:
AGENCY/SCHOOL:	PHONE:

REFERRAL FOR ☐ YOUTH ☐ PARENT/CAREGIVER ☐ FAMILY

LAST NAME:	FIRST NAME:	
BIRTHDATE: DAY / MONTH / YEAR	AGE:	CARECARD #:
GENDER IDENTITY:	CULTURAL IDENTITY:	
STREET ADDRESS:	TOWN:	
PHONE:	CAN WE LEAVE A MESSAGE?: ☐ YES ☐ NO	
ALTERNATE PHONE:	EMAIL:	

FOR YOUTH REFERRALS ONLY

IS THE PARENT/CAREGIVER AWARE OF THE REFERRAL? ☐ YES ☐ NO

PARENT/CAREGIVER NAME:	PHONE:
ADDITIONAL CONTACT NAME:	PHONE:

REASON FOR REFERRAL

RELEVANT INFORMATION: Please include strengths, current support systems, factors that may support engagement, risk factors and/or barriers to contacting youth or family.

PLEASE ENSURE THAT THE PERSON(S) BEING REFERRED HAS BEEN INFORMED OF THE REFERRAL.

FOR OFFICE USE ONLY. Form completed by: