DISCOVERY YOUTH AND FAMILY SUBSTANCE USE SERVICES
530 Fraser St-2nd Floor, Victoria, BC V9A 6H7
Ph: 250-519-5313, Fax: 250-519-5314 **www.viha.ca/youth-substance-use**

Info Session ☐ **IIA** ☐ **Direct Referral** ☐ **For Internal Use Only** Intake Counsellor: _____
Counsellor: _____ Date/Time: _____
Family: **Y N** # attend: ___ Individual: **Y N** # attend___ Other: eg PO _____Location: _____

REFERRING AGENT INFORMATION:

Person calling:	**Relationship:**	**Date:**
Home Phone:	**Work Phone:** Ext.	**Cell Phone:**
Discovery to contact referral agent: Y ☐ N ☐	**Discovery to contact the client directly:** Y ☐ N ☐	
Referring Agent:		**Date:**
Work Phone:	**Cell Phone:**	**Email:**

School: ☐ **MCFD Child Protection:** ☐ **MCFD CYMH:** ☐ **Youth Justice:** ☐
Parent/Caregiver: ☐ **Self:** ☐ **Family Dr:** ☐ **VGH Crisis MH:** ☐
IH Youth Clinic: ☐ **Youth Detox:** ☐ **Other:** _____

CLIENT INFORMATION: GIVEN NAME:

Preferred Name:	**DOB:**	**Age:**	**M** ☐ **F** ☐ **U** ☐
Address:			**Postal code:**
School: **Gr:**	**Family Dr:**		**PHN#**
Home Phone: **message:** ☐ **Y** ☐ **N**	**Cell Phone:** **message:** ☐ **Y** ☐ **N**		**Email:**
Guardian/Caregiver:			**Contact #:**
Has the person received services from Discovery in the past? ☐ **Y** ☐ **N**			**Counsellor:**

REASON FOR REFERRAL

YOUTH / FAMILY CONSENT TO REFERRAL

The Parents/Caregivers of this youth are aware of the referral to Discovery Services :	**Y** ☐ **N** ☐
The reason for this referral has been explained to the client:	**Y** ☐ **N** ☐
The client agrees to the exchange of information between the Referring Agent and Discovery for the purpose of this referral:	**Y** ☐ **N** ☐
Client Signature:	

OUTCOME: **INFO SESSION ONLY:** ☐ **IIA BOOKED:** ☐ **NO SHOW:** ☐ **INTAKE NO SERVICE:** ☐