DIVERSEcity OFFICE USE ONLY

Referral Received Date: ______________________________ Counsellor Assigned: ________________________________

Assigned Date: _____________________________________ Assigned By: _______________________________________

COUNSELLING SERVICES CHILD & YOUTH REFERRAL FORM

Referral Guidelines

- Incomplete forms will not be accepted.
- A referral does not guarantee service. All referrals are screened prior to an intake interview.
- If you require notice of intake and assignment, please indicate below. Referring persons will be notified via email with the name of the assigned counsellor and anticipated start date.

Please note: any additional information sharing requires the client's consent.

Referral Program

Please pick **ONE** program and the corresponding language:

☐Child & Youth Mental Health Counselling

☐Arabic ☐Cantonese ☐Korean ☐Mandarin ☐Punjabi ☐Spanish

☐Prevention, Education, Advocacy, Counselling and Empowerment Program (PEACE)

☐Arabic ☐Farsi ☐French ☐Hindi ☐Punjabi ☐Spanish ☐Urdu

Referral Information

Name: ____ Agency/Relationship to Client: _______________________________

Email: ____ Phone Number: ____

Date of Referral: ________________________________ Notification of assignment & anticipated start date ☐Yes ☐No

Has this referral been discussed with the client: Yes ☐ No ☐

Client Information

Child/Youth Name: _______________ _______________ Date of Birth: _______________________ Gender: _______________

(First name) (Last name) (year/month/date)

Parent / Caregiver Name (if required) ____________________ ___________________

(First name) (Last name)

Address: ____ City/Province: ___________________ Postal Code: ___________

Language: ___________________ Primary Phone #: ________________ Ethnic Background: _________________________________

Primary Reason for Referral *(**Please be specific and provide relevant details to ensure meeting program criteria**)*:

(Please attach additional notes as necessary)

Goals for Counselling:

1) ____

2) ____

3) ____

DIVERSEcity Community Resources Society – Counselling Services
13455 76 Avenue, Surrey, BC V3W 2W3 | Tel: 604-547-1202 | Fax: 604-597-0488 | dcrs.ca

DIVERSEcity
community resources society

Fill for Prevention, Education, Advocacy, Counselling and Empowerment Program (PEACE) only:

Who has custody of the child/youth? __________________ Are there any contact restrictions for either parent? ☐Yes ☐No

Details:

Mother's Name: ____________________ ____________________ Phone #: ________________
(First name) (Last name)

Address: ____ City/Province: ___________________ Postal Code: ___________

Language: ______________________________ Ethnic Background: ______________________

Father's Name: _____________________ _____________________ Phone #: ________________
(First name) (Last name)

Address: ____ City/Province: ___________________ Postal Code: ___________

Language: ______________________________ Ethnic Background: ______________________

Please complete and submit the form online to counsellingservices@dcrs.ca or via fax.

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