

DIVERSEcity Office Use Only

Referral Received Date:
Screening Completion Date:
Staff Assigned:

Assigned By:
Date Assigned:

Section 1: Client Information

Client's Name (First and Last Name): Gender: Date of Birth: Phone:
Can we leave a message? Yes No

Address: City: DD/MM/YYYY Email:
Province: Postal Code:

Preferred Language of Service: Cultural Background: How comfortable is the client with service in English?

Not comfortable at all
Slightly comfortable
Comfortable
Very comfortable

Section 2: Reasons for Referral

Support is required in the following areas: *(Please check all that apply)*

Depression	Family conflict and/or violence	Suicidality	Other
Anxiety	Connection and relationships	Homicidality	
Trauma	Parenting	Self-harm	
Substance use and/or addiction	Attachment	Concurrent disorder – diagnosed	
Settlement issues	Discrimination	Concurrent disorder – suspected	
Legal Issues	Outreach and accompaniment	Co-occurring mental health and substance use challenges	

Please share any other relevant information for the reason for referral:

Section 3: Referral Source Information

(Please do not fill out this section if you are self-referring.)

Name: Relationship to client: Agency (if applicable):

Phone: Email: Do you require notice of intake and assignment? Yes No

Please confirm that the client has consented to this referral: Yes No

If not, please explain:

How did you hear about our services?

Referral Guidelines

- Incomplete forms will not be accepted.
- A referral does not guarantee service. All referrals are screened at intake.
- If you require notice of intake and assignment, the client's consent will be required to notify you of the name of the assigned staff and anticipated start date.
- Please note that any additional information sharing requires a client's consent.
- Please email completed form to intake@dcrs.ca or fax to 604-597-0488.