

Valley Community Services

Box 187, 915 Pine Street, Creston, B.C. V0B 1G0
Phone (250) 428-5547 Fax (250) 428-5175 Email admin@valley.services
www.valley.services

Referral Form

Date: _____

Name of person in need of service: _____

Date of birth: _____ Male / Female Age: _____

Address: _____ Postal Code: _____

Email Address: _____

Phone: Home _____ Okay to leave a message at this number? Yes No

Cell _____ Text: Yes No

Family Members (including parents and children)

Name: _____ D.O.B.: _____ Phone: _____

Is the person being referred having any suicidal thoughts? Yes No

Are you concerned for this person's safety or someone else's safety? Yes No

Please explain:

Is the person being referred indigenous? Yes No

Emergency Contact #1: Name: _____ Phone: _____

Relationship: _____

Emergency Contact: #2 Name: _____ Phone: _____

Relationship: _____

Support People: (include service providers where applicable)

Family Doctor: _____ Psychiatrist/Paediatrician: _____

Medical Information/history:

School: _____ Current Grade attending: _____

Who has legal guardianship of the child(ren)? _____

Please give YOUR name and relationship to person being referred:

Name: _____

Relationship: _____

Is the person you are referring in agreement with this referral? Yes No

Is the person currently receiving other services? Yes No
Please Describe _____

Has the person received services in the past? Yes No
Please Describe _____

What are the main concerns at this time?

Family Conflict

Developmental Concerns (0-6 years)

Sexual Abuse

Sexual Assault

School related issues

Parenting issues

Historic Abuse

Pregnancy related issues

Current Abuse

Childhood Abuse

Mental Health Issues such as anxiety, depression, eating issues, etc.

Other: _____

Reason for Service Request:

Other Information: