



## OUTREACH THERAPY FAMILY CONNECTIONS PROGRAM

### Early Childhood Mental Health Program

4325 Neill Street, Port Alberni, B.C. V9Y 1E5

Phone: 250-723-1117 Fax: 250-723-7349

E-mail: [programs@outreachtherapy.org](mailto:programs@outreachtherapy.org)

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### REFERRAL FORM

**DATE OF REFERRAL:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Day Month Year

**NAME OF CHILD:** \_\_\_\_\_, \_\_\_\_\_  
(Legal Last Name) (First Name)

**Birthdate:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Gender:** \_\_\_\_\_  
Day Month Year

**Parents:** \_\_\_\_\_ **Legal Guardian:** \_\_\_\_\_  
\_\_\_\_\_  
(If Applicable) \_\_\_\_\_

**Address:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Postal Code:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Cel Phone:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Other Services / professionals involved with your child:** \_\_\_\_\_

**Preschool, Daycare, or School attending, if any:** \_\_\_\_\_

**Reason for Referral:** (Please provide brief description for reason of referral. If more space is needed, please add an extra page)

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**Has Parent been informed of the referral:** Yes No

**Okay to leave message on parent answering machine:** Yes No

**Referred By:** \_\_\_\_\_

**Agency / Profession:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Email:** \_\_\_\_\_