Outreach Therapy Family Connections Services

Early Childhood Mental Health Program

4325 Neill Street, Port Alberni, B.C. V9Y 1E5
Phone: 250-723-1141 Fax: 250-723-7349
programs@outreachtherapy.org

REFERRAL FORM

NAME OF CHILD: _____, _____ ☐ M ☐ F
(Legal Last Name) (First Name)

Birthdate: _____ / _____ / _____
Day Month Year

Parents: _____	*Legal Guardian:* _____ *(if applicable)*
Address: _____	*Address:* _____
City: _____	*City:* _____
Postal Code: _____	*Postal Code:* _____
Telephone: _____	*Telephone:* _____
Alternative: _____	

Family Physician: _____

Other services and/or professionals involved with your child (past and present): _____

_____

Preschool, Daycare, or School attending, if any: _____

REASON FOR REFERRAL: (Please give a brief description of your concerns. Continue on back of sheet if more room is needed.)

_____

_____

_____

_____

Has Parent Been Informed of Referral? Yes ☐ No ☐

Okay to Leave Message on Parent Answering Machine? Yes ☐ No ☐

Referred by: (please print) _____

Date of Referral: _____

Signature: _____ Agency: _____
(eg. Parent, MD, PHN, SW, etc.)

Address: _____ Telephone: _____