



FAMILY-TEEN MEDIATION REFERRAL

Referral Date:				
Self Referral? Yes No	If no, Referral Source:			
Referral Name:	al Name: Position/Role:			
Office Phone:	e Phone: Cellular Phone:			
Email:	Fax:			
Family Requesting Service				
Parent/Guardian's Last Name: _	First Name:			
Preferred Name:				
Gender: Prono	uns: Do you Identify as Indigenous? Yes No			
Street Address:	Postal Code:			
Phone:	Email:			
Preferred method for initial contact	t: Phone Email			
Parent/Guardian's Last Name: _	First Name:			
Preferred Name:				
Gender: Pronc	ouns: Do you Identify as Indigenous? Yes No			
(If different from above)				
Street Address:	Postal Code:			
Phone:	Email:			
Preferred method for initial contact	t: Phone Email			

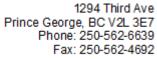


Intersect
Youth & Family Services

1294 Third Ave Prince George, BC V2L 3E7 Phone: 250-562-6639 Fax: 250-562-4692

Primary Youth Accessing Services:

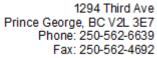
Youth's Last Name:		_ First Name	<u></u>	
Preferred Name:		_ Age:	DOB:	
Gender:	Pronouns:	Do you ld	entify as Indigenous? Yes No	
(If different from above)				
Street Address:		Postal Code:		
Phone:	E	mail:		
Preferred method for init	ial contact: Phone	Email		
Other Youth (12 yrs & 0	Older) in Home/Family:			
Youth's Last Name:		First Name:		
Preferred Name:		_ Age:	DOB:	
Gender:	Pronouns:	Do you ld	entify as Indigenous? Yes No	
(If different from above) Street Address:			_ Postal Code:	
Phone:	E	mail:		
Preferred method for init	ial contact: Phone	Email		
Youth's Last Name:		_ First Name	:	
Preferred Name:		_ Age:	DOB:	
Gender:	Pronouns:	Do you ld	entify as Indigenous? Yes No	
(If different from above) Street Address:			_ Postal Code:	
Phone:	Er	mail:		
Preferred method for init	ial contact: Phone	Email		





General Information

Is everyone listed on this form aware they have been referred for Mediation Services? Yes No If no, why?
Reason for Referral:
What is the youth and caregivers are hoping for as an outcome?
Is there a MCFD Social Worker supporting youth or caregivers? Yes No If yes, please provide their name and contact information:
Current Custody/Access Situation:
Other Professionals/Agencies Providing Service to Youth or Caregivers?





Are there any special service considerations we should be aware of to support this family? (Barriers,					
fears, disabilities etc.)					
Are there any health care need	s we should be aware of? (Alle	ergies, diagnosis, recent hospitalization)			
la thara any additional informat	ion we about he aware of at t	hia tima?			
Is there any additional informat	ion we should be aware or at t	nis time?			
		sting services must sign their consent services Family-Teen Mediation Team.			
D01010 1/110 00114 4 1010114 11	Theorem Touristics and Taning C	orvious raining room measurem realist			
Intersect Youth and Family S	ervices on behalf of	to the Family-Teen Mediation with I am aware that your			
,	y and that you will contact me ough with accessing services.	when you receive this referral, but it is			
Youth	Caregiver/Guardian	Caregiver/Guardian			

^{**}Please fax completed referral form to 250-562-4692, Attention Family-Teen Mediation Program**