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

FAMILY-TEEN MEDIATION REFERRAL

Referral Date: ______________________________

Self Referral? ☐ Yes ☐ No If no, Referral Source: ___________________________________

Referral Name: __________________________________ Position/Role: __________________________

Office Phone: ___________________________ Cellular Phone: _________________________________

Email: ____ Fax: ________________________________

Family Requesting Service

Parent/Guardian's Last Name: _________________________ First Name: ______________________

Preferred Name: ______________________________________

Gender: _______________ Pronouns: ______________ Do you Identify as Indigenous? ☐ Yes ☐ No

Street Address: ____ Postal Code: ____________________

Phone: __________________________________ Email: ____

Preferred method for initial contact: ☐ Phone ☐ Email

Parent/Guardian's Last Name: ________________________First Name: ________________________

Preferred Name: _____________________________________

Gender: _______________ Pronouns: ______________ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)

Street Address: ____ Postal Code: ____________________

Phone: __________________________________ Email: ____

Preferred method for initial contact: ☐ Phone ☐ Email

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Primary Youth Accessing Services:

Youth's Last Name: ____________________ First Name: ____________________

Preferred Name: ____________________ Age: __________ DOB: ____________

Gender: ___________ Pronouns: ___________ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)
Street Address: ______________________________ Postal Code: ____________

Phone: ____________________ Email: ____________________

Preferred method for initial contact: ☐ Phone ☐ Email

Other Youth (12 yrs & Older) in Home/Family:

Youth's Last Name: ____________________ First Name: ____________________

Preferred Name: ____________________ Age: __________ DOB: ____________

Gender: ___________ Pronouns: ___________ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)
Street Address: ______________________________ Postal Code: ____________

Phone: ____________________ Email: ____________________

Preferred method for initial contact: ☐ Phone ☐ Email

Youth's Last Name: ____________________ First Name: ____________________

Preferred Name: ____________________ Age: __________ DOB: ____________

Gender: ___________ Pronouns: ___________ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)
Street Address: ______________________________ Postal Code: ____________

Phone: ____________________ Email: ____________________

Preferred method for initial contact: ☐ Phone ☐ Email

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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?

____

____

____

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Are there any special service considerations we should be aware of to support this family? (Barriers, fears, disabilities etc.)

____

____

____

Are there any health care needs we should be aware of? (Allergies, diagnosis, recent hospitalization)

____

____

____

____

Is there any additional information we should be aware of at this time?

____

____

____

As a referring agency I/We understand that a family requesting services must sign their consent before I/We send a referral to Intersect Youth and Family Services Family-Teen Mediation Team.

I/We support and acknowledge this referral has been made to the Family-Teen Mediation with Intersect Youth and Family Services on behalf of ______________________. I am aware that your services are entirely voluntary and that you will contact me when you receive this referral, but it is my responsibility to follow through with accessing services.

______________________	______________________	______________________
Youth	Caregiver/Guardian	Caregiver/Guardian

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