



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: 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

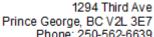


Intersect
Youth & Family Services

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: _	
Preferred Name:		_ Age:	DOB:
Gender:	Pronouns:	Do you Ide	ntify as Indigenous? Yes No
(If different from above)			
Street Address:			Postal Code:
Phone:	E	mail:	
Preferred method for initia	I contact: Phone	Email	
Other Youth (12 yrs & Ol	der) in Home/Family:		
Youth's Last Name:		_ First Name: _	
Preferred Name:		_ Age:	DOB:
Gender:	Pronouns:	Do you Idei	ntify as Indigenous? Yes No
(If different from above) Street Address:		1	Postal Code:
Phone:	E	mail:	
Preferred method for initia	I contact: Phone	Email	
Youth's Last Name:		_ First Name: _	
Preferred Name:		_ Age:	DOB:
Gender:	Pronouns:	Do you Ider	ntify as Indigenous? Yes No
(If different from above) Street Address:		I	Postal Code:
Phone:	E	mail:	
Preferred method for initia	I contact: Phone	Email	





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General Information

Please note that this service is voluntary! It is important that all members listed on this form are aware of this opportunity & are willing to meet with the Mediator to learn about this service and how it might support positive changes in the family/relationships. *The caregiver and/or youth must provide consent at the end of this referral for it to be accepted for Family Teen Mediation services*.

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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ears, disabilities etc.)		vare of to support this family? (Barners,
Are there any health ca	re needs we should be aware of? (Alle	ergies, diagnosis, recent hospitalization)
s there any additional	information we should be aware of at t	his time?
consent before this re	on, it is understood that the family bein eferral is submitted to Intersect Youth a f verbal consent given – please note be	
Family-Teen Mediat	ion program. I am aware this service at me once the referral is accepted b	
Youth	Caregiver/Guardian	Caregiver/Guardian
Note if verbal conser	t was given & by whom:	

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