



**REFERRAL FORM**

**CLIENT INFORMATION:**

Full Name:	DOB (MMM DD YYYY):
Preferred Name:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans <input type="checkbox"/> Other
Address:	
Telephone:	Alternate Telephone:
Minor/Under Age of 18: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes please fill out parent/guardian's contact information below)	
Child in Care: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Parent/Guardian Name:	
Telephone:	Alternate Telephone:
Client identifies with the following (check all that applies):	
<input type="checkbox"/> First Nations <input type="checkbox"/> Status <input type="checkbox"/> Non-Status <input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> Other (please specify): _____	
Status # and/or First Nations Band Affiliation (if applicable): _____	

**REQUESTED SERVICES (please select top 3):** Please check our website to confirm eligibility criteria.

**O'SIEM EARLY CHILDHOOD DEVELOPMENT PROGRAMS:**

- Prenatal
- Doula Services
- Postnatal
- AECD Outreach
- My Urban Elder
- Taking Care of Your Children
- Bringing Tradition Home
- Awahsuk Headstart Preschool
- Reclaiming Connections

**CHILDREN, YOUTH AND FAMILIES WITH EXTRA SUPPORT NEEDS:**

- Aboriginal Infant Development Program
- Family Connections
- In-Home Parent Support
- FASD Keyworker
- Indigenous Domestic Violence Program (IDVP) Community Liaison
- Family Wellness Traditional Counsellor
- IDVP Individual/Couples Counselling

**YOUTH AND YOUNG ADULT:**

- Youth Connections       Youth Urgent Needs       Youth Addictions Outreach  
 All Nations Youth Safe House    Youth Outreach/Empowerment    Youth Culture Nights  
 Surrey Indigenous Youth Advisory Council

**HEALTH & WELLNESS:**

- Positive Health- Fraser North       Harm Reduction – Fraser North       Addictions Counselling  
 Positive Health- Fraser East       Harm Reduction – Fraser East       Red Path  
 Traditional Elder Counselling       Indigenous Health & Wellness Clinic

**HOUSING AND HOMELESSNESS PREVENTION:**

- Housing Outreach       Homeless Prevention       Homeless Outreach  
 Residential Tenancy Advocacy       Evictions Specialist

**AGENCY REFERRAL SOURCE:**

Referrer's Name:	Agency:
Phone:	Fax:
Email:	
Reason for Referral:	
Client is aware of the referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>**Please ensure that the client is informed of this referral. This is important for informed consent and relationship building.**</b>	
Signature:	Date:

**\*\* Please fax referrals to 604-595-1176 \*\***