**Kids in Control & Teens in Control Referral Form**

**Referrer Information**

|  |  |
| --- | --- |
| Referrer: | Click or tap here to enter text. |
|  | *Name* | *Agency (if applicable)* |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number: | Click or tap here to enter text. | Email Address: | Click or tap here to enter text. |

**Participant Information**

|  |  |  |
| --- | --- | --- |
| Name: | Click or tap here to enter text. | Click or tap here to enter text. |
|  | *First* | *Last* | *Preferred Name* |

|  |  |  |  |
| --- | --- | --- | --- |
|  Birth Date: | Click or tap to enter a date. |  Age: | Click or tap here to enter text. |
| Gender: | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Name of Parent/ Guardian(s): | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. | Click or tap here to enter text. |
|  | *Street Address* | *Apartment/Unit #* |

|  |  |  |
| --- | --- | --- |
|  | Click or tap here to enter text. | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
|  | *City* |  | *Postal Code* |
| Primary Phone: | Click or tap here to enter text. | Alternate Phone: | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Email: | Click or tap here to enter text. |
| Family Member Living with Mental Illness: | Click or tap here to enter text. | Diagnosis (If known): | Click or tap here to enter text. |
| Participant’s level of awareness of mental illness: | Click or tap here to enter text. |

**Independent Youth Information**

|  |  |
| --- | --- |
| Social Worker: | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number: | Click or tap here to enter text. | Email Address: | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Youth Worker: | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number: | Click or tap here to enter text. | Email Address: | Click or tap here to enter text. |

 **Other Information**

|  |  |
| --- | --- |
| Is help with transportation (bus tickets) required? | Click or tap here to enter text. |

Please describe any allergies, medicial conditions or medications that facilitators should be aware of:

Click or tap here to enter text.

Who is part of the participant’s support system?

Click or tap here to enter text.

What are the participant’s favourite activities and interests?:

Click or tap here to enter text.

Additional information or concerns:

|  |
| --- |
| **Form completed by:** Click or tap here to enter text. **Date:** Click or tap to enter a date.**Please return forms by email, or call to arrange pick-up:**Melissa Michaud, Mental Health and Family Support EducatorEmail: nelson@bcss.orgPhone: 250-505-2976 |

Click or tap here to enter text.