



Hulitan Referral Form

Referral Source	Date Referred: _____	
Referral Source: _____ Agency Name: _____		
Phone number: _____ Email address: _____		
Are the parents/guardians aware of this referral?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Is the Youth aware of this referral?	<input type="checkbox"/> yes <input type="checkbox"/> no	
What Program are you referring to :		
<input type="checkbox"/> NIŁ YEŁ OLs Program Sexual Abuse Intervention Program	<input type="checkbox"/> Ł, KI, L Program Aboriginal Child & Youth Mental Health	
Demographics of Family		
Main Client: _____	Date of Birth: _____	
Contact Number: _____	Email address: _____	
Family Members:		
Name	Role	Date of Birth

Living Situation for Children:		
<input type="checkbox"/> Family Home <input type="checkbox"/> Foster care (Temp) <input type="checkbox"/> Kith & Kin (MCFD) <input type="checkbox"/> Child in home of relative (MHR)		
Presenting issue(s)/reasons for referral:		

Has the client/family had previous MCFD involvement? <input type="checkbox"/> yes <input type="checkbox"/> no		
If Yes, please state date(s) and level of care		

Hulitan Family & Community Services Society Fax # 250-384-9467 Phone # 250-384-9466		