



Date Referred:	Referral Phone #
Referral Source (Name/Organization)	

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
Is the child aware of this referral?	<input type="checkbox"/> yes <input type="checkbox"/> no

## Program Descriptions

**FPRP** – To provide intensive interventions to families involved with MCFD or Delegated Aboriginal Agency (DAA) due to child protection concerns. Includes stabilization, integration, and maintenance stages. Parent-child observations occur throughout the program. **Must have MCFD or DAA Social Worker involved.**

**NIŁ YEŁ OLS-** To provide counseling and support to Indigenous children and youth aged 0-19 and their families who have experienced or at risk of sexualized violence.

**Ł,KI,L** – To provide counselling and support to Indigenous children and youth aged 0-19 and their families presenting with mental health issues.

**Healing Generations** - To provide counselling and support to Indigenous adults, children, youth and families who have been impacted by sexualized violence.

## Program Referring To (Select one. If multiple programs required, please fill out individual forms):

Family Preservation Reunification Program (FPRP)	<input type="checkbox"/>
NIŁ YEŁ OLS (Sexual Abuse Intervention Program)	<input type="checkbox"/>
Ł,KI,L (Indigenous Child & Youth Mental Health)	<input type="checkbox"/>
Healing Generations (SARCP)	<input type="checkbox"/>

Adult/Parent/Caregiver being referred:	Phone Number/Email:	Voicemail/text? (Y or N)
1.		
2.		
<b>Children (Please include Birthdate and Ancestry)</b>		
1.	3.	
2.	4.	



### Presenting Concerns/Reasons for Referral:

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### Section 13 Child Protection Concerns (for Family Preservation Reunification Program only):

- |   |   |
|---|---|
| <input type="checkbox"/> Domestic Violence        | <input type="checkbox"/> Neglect                |
| <input type="checkbox"/> Substance Misuse         | <input type="checkbox"/> Abuse                  |
| <input type="checkbox"/> Housing/Home Maintenance | <input type="checkbox"/> Mental Health Concerns |
| <input type="checkbox"/> Parenting Skills         | <input type="checkbox"/> Additional             |

### If MCFD is involved, please indicate the status of the file (VCA, TCO, CCO, Supervision Order, Investigation, Permanency Planning):

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### Who are the children currently living with (Family – Parents/Extended Family, Foster Placement):

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Child(ren)'s Current Caregiver(s):	Contact Information:	Voicemail/text? (Y or N)
1.		
2.		

### Please note any past or present concerns related to:

Mental Health (e.g. anxiety, isolation, eating concerns, depression): \_\_\_\_\_

Alcohol/Drug Use: \_\_\_\_\_ +

Harm to Self (thoughts/attempts of suicide/cutting): \_\_\_\_\_

Harm to Others (physical, sexual, emotional violence): \_\_\_\_\_