



Spirit of the Children

201- 768 Columbia Street, New Westminster, B.C.V3M 1B4 phone 604-524-9113, fax 604-524-9124

SOTCS NEW FILE # _____

SOTCS Re-open File _____

Referral Form

Referral Date: D/____M/____Y/____

Referred By: Please check off one of the boxes below for referral

Self/Walk In

Ministry of Child and Family Development (MCFD)

Open MCFD File?

Reports Required for MCFD?

Other (example: school, community centre, hospital, friend/relative, other organization, *or* Spirit of the Children employee)

Name of Worker: _____

Address: _____

City: _____, Province: _____, Postal Code: _____

Tel: _____, Fax: _____, Email: _____

Referral(s)/Applicant(s) Address Information:

Applicant 1

Last Name: _____ First Name: _____

Address: Apt # _____ Street Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Email: _____

Date of birth: (dd/mm/yyyy) _____ Status Non Status Metis Other

Supervision Order dates and conditions: _____

Court Order dates and conditions: _____

Applicant 2

Last Name: _____ First Name: _____

Address: apt # _____ Street address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Email: _____

Date of birth: (dd/mm/yyyy) _____ Status Non Status Metis Other

Child(ren) Referred Information:

	Last Name:	First Name	DOB (dd/mm/yyyy)	Status/NonStatus/ Metis/Other	Band Affiliation	With applicant/ referral?	In Care?
1				<input type="checkbox"/> Status <input type="checkbox"/> Non Status <input type="checkbox"/> Metis <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2				<input type="checkbox"/> Status <input type="checkbox"/> Non Status <input type="checkbox"/> Metis <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3				<input type="checkbox"/> Status <input type="checkbox"/> Non Status <input type="checkbox"/> Metis <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4				<input type="checkbox"/> Status <input type="checkbox"/> Non Status <input type="checkbox"/> Metis <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5				<input type="checkbox"/> Status <input type="checkbox"/> Non Status <input type="checkbox"/> Metis <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If child(ren) not living with applicant/referral:

Name of guardian: _____ Relationship: _____

Address: apt # _____ street address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Email: _____

Previous contact with Spirit of the Children:

u Have you accessed services from Spirit of the Children before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been referred/referred this family to Spirit of the Children before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, date of last visit: _____		
What programs did you attend? _____		
Name of Spirit of the Children Worker: _____		

Reason for Referral/Attendance:

Goals:

Programs referred/registering for: (Select a maximum of three programs from those listed below.)

Early Childhood Development Programs			
<input type="checkbox"/> Infant Development Program	<input type="checkbox"/> Prenatal program (Obin Ni'i)	<input type="checkbox"/> Family Drop-in Program	<input type="checkbox"/> Literacy Program
<input type="checkbox"/> Community Resource Worker/FASD	<input type="checkbox"/> Parenting Support	<input type="checkbox"/> ECD Outreach	
Family Development Programs			
<input type="checkbox"/> Family Strengthening Program	Aboriginal Parenting Program (TAPP): <input type="checkbox"/> Men's Program <input type="checkbox"/> Women's Program	<input type="checkbox"/> Men's Paintball	<input type="checkbox"/> Beading Program
<input type="checkbox"/> Community Greeter	<input type="checkbox"/> Family Circle <input type="checkbox"/> Men's Circle <input type="checkbox"/> Women's Circle	<input type="checkbox"/> Traditional Kitchen	
Youth Programs			
<input type="checkbox"/> Iskwew Girls Group	<input type="checkbox"/> Band of Brothers group	<input type="checkbox"/> Youth Programs	<input type="checkbox"/> Youth Circles
0			

I have read and agree with this referral: (Please ensure each party listed below signs and prints their name in the provided space).

_____	_____	_____	_____
Family Applicant 1	signature	Family Applicant 2	signature
_____	_____	_____	_____
Social Worker	signature	Team Leader	signature
_____	_____	_____	_____
Intake Manager	signature	Family Strengthening Worker	signature

		Date Received	