



Date: _____

To be completed by the referral source (if applicable)

Are you referring on behalf of a youth? YES NO

If yes, Is the youth aware that you are contacting us on their behalf? YES NO

Name of referral source: _____

Contact information for referral source: _____

Referral information

Name: _____

Gender: _____

Date of Birth (year/month/day) – the program is for youth 14 to 24: _____

Current Address: _____

Please provide the best contact information: _____

Can we leave a message? YES NO

Language preference: _____

Is there or has there been any connection to the provincial child welfare system? I.e. Have you ever had a social worker, been involved with YES (Youth Engagement Services), or visited a social worker at school? YES NO

In order to best support – please answer the following questions to the best of your ability.

What are the current Mental Health concerns? _____

Is there a history of trauma? YES NO

Has there been any thoughts of ending your life by suicide recently? YES NO

If there is any danger of harm, please contact 911 immediately

Is there anything else you would like us to know? _____

Partners for Youth
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