



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: \_\_\_\_\_ Ethnicity (optional): \_\_\_\_\_

Date of birth (year/month/day) – **the program is for youth 14 to 24:** \_\_\_\_\_

*\*Youth under 16? (we will need guardian consent)*

Guardian Name and Contact Information: \_\_\_\_\_

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? \_\_\_\_\_

**To be completed by Youth referred:**

I give consent to PFY Connect Staff Members to talk to service providers to set up counselling services.

YES NO

\*Please note – a detailed consent form will be given before counselling services start

Partners for Youth Inc.  
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