



## Client Details

### CLIENT 1

Full name:		Pronouns:	Gender:
Does client identify as Indigenous? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES: <input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit			Date of birth: YYYY-MM-DD
Mailing address:		Emergency contact number:	
Physical address:		Emergency contact name and relation:	
Phone number (authorized for us to contact you):	May we leave voice messages? <input type="checkbox"/> YES <input type="checkbox"/> NO	Email address:	

### CLIENT 2 (IF APPLICABLE)

Full name:		Pronouns:	Gender:
Does client identify as Indigenous? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES: <input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit			Date of birth: YYYY-MM-DD
Mailing address:		Emergency contact number:	
Physical address:		Emergency contact name and relation:	
Phone number (authorized for us to contact you):	May we leave voice messages? <input type="checkbox"/> YES <input type="checkbox"/> NO	Email address:	

### CHILD DETAILS (IF APPLICABLE)

CHILD 1	CHILD 2	CHILD 3	CHILD 4
Name:	Name:	Name:	Name:
Date of birth: YYYY-MM-DD	Date of birth: YYYY-MM-DD	Date of birth: YYYY-MM-DD	Date of birth: YYYY-MM-DD
Does child identify as indigenous? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES: <input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit	Does child identify as indigenous? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES: <input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit	Does child identify as indigenous? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES: <input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit	Does child identify as indigenous? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES: <input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit
Gender:	Gender:	Gender:	Gender:
Who does child reside with?	Who does child reside with?	Who does child reside with?	Who does child reside with?
Other important information:	Other important information:	Other important information:	Other important information:

**ADDITIONAL CLIENT INFORMATION**

Does the client have a parent, guardian or other relative with contact information? Is there child custody, protection, or child-in-care information we should be aware of? Are there accessibility needs? Please enter any integral information regarding referred clients here:

If there is a pertinent court order, is a copy included:  YES  NO

If applicable, what relevant services/programs is the client already participating in, external to CFEC?

If applicable, has the client completed any relevant assessments? Are the assessments being submitted with this referral? If not, why?

**Requested Service:**

- Counselling Services:
  - Individual Counselling
  - Family Therapy/Mediation
  - Relationship Counselling
  - Other: \_\_\_\_\_
- Early Years Services/CCRR:
  - Affordable Child Care Benefit Assistance
  - Child Care Resource and Referral
  - Early Years Screening
  - Prenatal Nutrition Program
  - Other: \_\_\_\_\_
- Fetal Alcohol Spectrum Disorder/Complex Developmental Behavioural Conditions (FASD/CDBC) Keyworker
- Family Support Services:
  - Family Group Conference
  - Healthy Care Pregnancy Program In-Reach Worker
  - Parenting Education/Support
  - Other: \_\_\_\_\_
- Youth Support Services:
  - Youth Agreement/Transition Planning
  - Youth Counselling
  - Youth Support (Mentorship/Life Skills)
  - Other: \_\_\_\_\_
- Group Course
  - Course Name: \_\_\_\_\_
- Community Navigator
- Other (please define): \_\_\_\_\_

**Description of situation and/or services requested:**

Empty box for description of situation and/or services requested.

**Goal(s) for client(s):**

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**Referring Agency (if Applicable)**

Agency name:	Referral date: YYYY-MM-DD
Worker name:	Contact phone number:

**Service Agreement**

I have read this form and had the opportunity to ask questions, and I agree to this request for services. I understand a CFEC Employee will contact me within 10 business days for intake purposes. I understand I must submit government-issued photo identification as part of requesting services from CFEC.

Client name:	Client signature:	Signing date: YYYY-MM-DD
2 <sup>nd</sup> Client name (if applicable):	2 <sup>nd</sup> Client signature (if applicable):	Signing date: YYYY-MM-DD
Referring worker's name:	Referring worker's signature:	Signing date: YYYY-MM-DD

**CFEC INTERNAL USE ONLY**

Supervisor:	Referred to:	Referral Date: YYYY-MM-DD	Past Services: <input type="checkbox"/> YES <input type="checkbox"/> NO
Notes:			