Client File #_____

South Vancouver Island
Jordan's Principle
Referral Form

This information will be used to process this referral.

Child's Name:		**Date of Referral:**	____ /____ /_____ mm/dd/yyyy
Child's Birthdate:	____ /____ /_____ mm/dd/yyyy	**Child's Gender:**	◯ Male ◉ Other ◯ Female
Ethnicity:	◯ First Nation ◯ Metis ◯ Inuit ◉ Other	**Status #:**	
		Parents Status #:	
Child's Resides:	◉ On Reserve ◯ Off Reserve	**Recognized by Band (required if no status #):**	◯ Yes ◉ No ☐ Has supporting documentation
Child's First Nation:		**Child's Health #:**	

Please describe known conditions related to referral (e.g. depression, cerebral palsy, ADHD, etc.):	
Reason for referral:	
Known barriers to services affecting child (e.g. no service access, funding, waitlist):	
Efforts taken to support the child prior to referral:	
Other notes:	

Caregiver Name:		◯ Parent ◉ Other, please explain ◯ Legal Guardian
Caregiver/Family Contact:	**Address:**	
	Home phone:	
	Cell phone:	
	Email:	

Referral Source Name:		**Referral source type:** ◯ Social professional (e.g. counsellor) ◯ Healthcare professional (e.g. nurse) ◯ Educational professional (e.g. teacher) ◯ Other professional (e.g. life skills coach) ◯ Parent/caregiver (e.g. mom) ◉ Other, please explain
Referral Source Organization:		

The parent/guardian is informed about this referral and wishes to participate. ☐ Yes ☐ No