P.E.A.C.E Program REFERRAL FORM

CLIENT (CHILD) NAME	REFERRAL SOURCE	REFERRAL DATE
GENDER (Circle one) M F	DATE OF BIRTH _____/_____/_____ D M Y	PERSONAL HEALTH NUMBER

CLIENT ADDRESS:			REASON FOR REFERRAL AND PRESENTING PROBLEMS
CITY/TOWN	POSTAL CODE:	☐	Witnessed Domestic Violence
HOME PHONE NUMBER: ( ) -	WORK NUMBER: ( ) -	☐	School Adjustment/Learning problems
NAME OF PARENT(S) LEGAL GUARDIAN(S):		☐	Behavior problems Describe:
NAME OF PRIMARY PHYSICIAN:	PHYSICIANS PHONE NUMBER: ( ) -	☐	Fearful/anxious
NAME OF SCHOOL ATTENDED BY CLIENT:		☐	Poor self worth
CURRENT MEDICATIONS:		☐	Abuse (Physical or emotional)
OTHER RELEVANT MEDICAL INFO:		☐	Loss & Grief
ALLERGIES:		☐	Peer/Family relationship problems
COMMENTS:		☐	Other (Please List) ____________________
IS CLIENT AWARE OF THIS REFERRAL? (Circle one) Yes No			STATUS (circle one) Y N BAND:________________
SIGNATURE OF REFERRAL SOURCE:			

FAX FORM TO: P.E.A.C.E. Program Coordinator
(250) 398-6115
EMAIL FORM TO: cariboo.cwwa@shawcable.com

DELIVER TO: 99 South 3rd Avenue Williams Lake, BC V2G 1J1