



**CARIBOO FRIENDSHIP SOCIETY**  
 99 South Third Avenue  
 Williams Lake, BC, Canada V2G 1J1  
 Phone: 250-398-6831 Fax: 250-398-6115  
 Email: [admin@cswl.ca](mailto:admin@cswl.ca)  
 Website: [www.cariboofriendshipsociety.ca](http://www.cariboofriendshipsociety.ca)

|                                  |              |
|----------------------------------|--------------|
| Hearth Restaurant                | 250-398-6831 |
| Native Arts & Craft Shop         | 250-398-6831 |
| Contracting                      | 250-398-6831 |
| Aboriginal Wellness Program      | 250-267-2377 |
| Pregnancy Outreach Program       | 250-392-3583 |
| Little Moccasins Learning Centre | 250-398-6841 |
| Little Mukluks Daycare           | 778-412-9282 |
| Urban Aboriginal Housing         | 250-398-6831 |
| Emergency Shelter                | 250-398-6831 |
| Chiwid Transition House          | 250-398-5658 |
| P.E.A.C.E. Program               | 250-398-7005 |
| Family Ties Program              | 250-267-3703 |
| Elder's Circle of Care           | 250-398-7921 |

**Aboriginal Child and Youth Mental Wellness Program – Referral Form**

|   |  |  |                                     |                                    |                              |
|---|--|--|-------------------------------------|------------------------------------|------------------------------|
| Client Name:  |  | Date of Birth:   |                                     | Gender:                            |                              |
| Address:  |  |  | City/Town:                          |                                    |                              |
| Postal Code:  |  | Email Address:   |                                     |                                    |                              |
| Client Home Phone:  |  |  | Client Cell Phone:                  |                                    |                              |
| Status: Yes <input type="checkbox"/> No <input type="checkbox"/>  |  | Urban <input type="checkbox"/>                                 | Name of School Attended by Client:  |                                    |                              |
| Affiliated Band:  |  | Rural <input type="checkbox"/>                                 |                                     |                                    |                              |
| Metis: Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |  |                                     |                                    |                              |
| Name of Parent(s)/Legal Guardian(s)/Caregiver(s):   |  |  |                                     |                                    |                              |
| 1) Name: _____  |  | Home Phone: _____  |                                     | Cell Phone: _____                  |                              |
| 2) Name: _____  |  | Home Phone: _____  |                                     | Cell Phone: _____                  |                              |
| 3) Name: _____  |  | Home Phone: _____  |                                     | Cell Phone: _____                  |                              |
| Name of Primary Physician or Psychiatrist:  |  | Previous/Current Mental Health Care and Dates (if applicable): |                                     |                                    |                              |
| Phone Number:   |  |  |                                     |                                    |                              |
| Current Medications, Allergies, Past Diagnosis (if available), or Other Relevant Medical Info:  |  |  |                                     |                                    |                              |
| Reason for Referral and Presenting Problem(s):  |  |  |                                     |                                    |                              |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Behaviour Problem                     | <input type="checkbox"/> Aggression | <input type="checkbox"/> Abuse     |                              |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Possible Psychosis                    | <input type="checkbox"/> Trauma     | <input type="checkbox"/> Self-Harm |                              |
| Suicidal Ideation: Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | Other (describe)   |                                     | Is Client Aware of this Referral?  | Urgent?                      |
| Suicidal Attempt (describe): Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |  |                                     | Yes <input type="checkbox"/>       | Yes <input type="checkbox"/> |
|   |  |  |                                     | No <input type="checkbox"/>        | No <input type="checkbox"/>  |
| Comments:   |  |  |                                     |                                    |                              |
| Referral Date:  |  |  | Referral Source Organization:       |                                    |                              |
| Referral Source Name (Print):   |  |  | Referral Source Signature:          |                                    |                              |
| Submit via: Fax: 250-398-6115, Email: <a href="mailto:awc@cswl.ca">awc@cswl.ca</a> or deliver to: 99 South 3 <sup>rd</sup> Ave, Williams Lake, BC, V2G 2E8.<br>Any questions? Call the Aboriginal Wellness Coordinator at 250-267-2377. |  |  |                                     |                                    |                              |

Response Date (office use only): \_\_\_\_\_