island health

DISCOVERY YOUTH AND FAMILY SUBSTANCE USE SERVICES
530 Fraser St-2nd Floor, Victoria, BC V9A 6H7
Ph: 250-519-5313, Fax: 250-519-5314 **www.viha.ca/youth-substance-use**

Info Session ☐ **IIA** ☐ **For Internal Use Only** Intake Counsellor: _____
Counsellor: _____ Date/Time: _____
Family: **Y N** # attend: ___ Individual: **Y N** # attend___ Other: eg PO _____Location: _____

REFERRING AGENT INFORMATION:

Person calling: **Relationship:** **Date:**

Home Phone: ( ) **Work Phone:** Ext. **Cell Phone:**

Discovery to contact referral agent: Y ☐ N ☐ **Discovery to contact the client directly:** Y ☐ N ☐

Referring Agent: **Date:**

Work Phone: ( ) **Cell Phone: ( )** **Email:**

School: ☐ **MCFD Child Protection:** ☐ **MCFD CYMH:** ☐ **Youth Justice:** ☐
Parent/Caregiver: ☐ **Self:** ☐ **Family Dr:** ☐ **VGH Crisis MH:** ☐
IH Youth Clinic: ☐ **Youth Detox:** ☐ **Other:** _____

CLIENT INFORMATION

Name:	**DOB:**	**Age:**	**M** ☐ **F** ☐ **U** ☐

Address: **Postal code:**

School: **Gr:**	**Family Dr:** **CareCard#**	
Home Phone: ( ) **message:** ☐ **Y** ☐ **N**	**Cell Phone: ( )** **message:** ☐ **Y** ☐ **N**	**Email:**

Guardian/Caregiver: **Contact #:**

Has the person received services from Discovery in the past? ☐ **Y** ☐ **N** **Counsellor:**

REASON FOR REFERRAL

YOUTH / FAMILY CONSENT TO REFERRAL

The Parents/Caregivers of this youth are aware of the referral to Discovery Services : Y ☐ N ☐

The reason for this referral has been explained to the youth: Y ☐ N ☐

The youth agrees to the exchange of information between Referring Agent and Discovery: Y ☐ N ☐

Youth Signature:

OUTCOME: **INFO SESSION ONLY:** ☐ **IIA BOOKED:** ☐ **NO SHOW:** ☐