



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: () **Cell Phone:** () **Email:** _____
message: Y N **message:** Y N
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: