

513 Bernard Avenue ∙ Kelowna, BC ∙ V1Y 6N9 ∙ Ph (250) 763-2977 ∙ Fax (250) 763-6060 ∙ Email: arcprograms@arcprograms.com ∙
Website: www.arcprograms.com

**REFERRAL FORM TO SCHOOL-BASED CHANGES D&A COUNSELLOR**

|  |  |  |
| --- | --- | --- |
| **Targeted Prevention (Cassy/Devan)** |[ ]  **Suspension**  |[ ]  **Changes (Kristi/Indy/Rob)** |[ ]

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:** |  | **Referred by:** |  |
| **School Admin** |[ ]  **Counsellor/CEA** |[ ]  **Teacher** |[ ]  **Parent** |[ ]  **FN Advocate** |[ ]  **Other** |[ ]
| **Phone #** |  | **Ext.** |  | **Email** |  |

|  |
| --- |
| **Youth’s Personal Data** |
| **Youth Name and Preferred Pronoun:** |
| **Date of Birth:** |
| Male [ ]  Female [ ]  Trans man/Trans female [ ]  Two-Spirit [ ]  Non-Binary [ ]  Genderqueer/gender Non-conforming (GNC)[ ]  Not stated (please state):  |
|  |
| **Age** |  | **Health #** |  | **School** |  |
| **Indigenous Descent** | **Y** | **☐** | **N** | **☐** | **Status** | **Y** | **☐** | **N** | **☐** | **Band Name** |  |
| **Address** |  | **Postal Code** |  |
| **Phone #** |  | **Cell #** |  |
| **Parent/Caregiver/Guardian Name(s)** |  |
| **Email/Address/Phone Number(if different than above)** |  |

|  |
| --- |
| **Reason for Referral** |
|  |
| **Substance Misuse** |
| **What do you know about youth’s history/patterns of substance misuse?** |
|  |
| **Impact of Use (Please check all that apply):** |
|  |
| **Skipping Class** |[ ]   | **School Suspension** |[ ]   | **Loss of Friends** |[ ]
| **Employment Absenteeism** |[ ]   | **Loss of Employment** |[ ]   | **Criminal Involvement/ Charge** |[ ]
| **Health Issues** |[ ]   | **Sexualized Behavior** |[ ]   | **Family Conflict** |[ ]
| **Hospitalization** |[ ]   | **Other** |[ ]   |  |  |
| **If other, please describe:** |  |  |
| **Is the youth aware of this referral?** | **Yes** [ ]  | **No** [ ]  |
| **Did the youth agree to this referral?** | **Yes** [ ]  | **No** [ ]  |
| **Is the youth mandated/required to come to this service?** | **Yes** [ ]  | **No** [ ]  |
| **Is the youth’s parent/caregiver aware of this referral?** | **Yes** [ ]  | **No** [ ]  |
| **How would you describe their school attendance?** | **Regular** [ ]  | **Infrequent** [ ]  | **Tardy** [ ]  |

|  |
| --- |
| **MENTAL/EMOTIONAL HEALTH CONCERNS, DIAGNOSES, CONDITIONS:** |
| **Do you know of any mental health concerns/issues?** | **Yes** [ ]  | **No** [ ]  |
| **Please check all that are applicable:** |
| **Criminal Behavior** | **☐** |  | **Eating Concerns** | **☐** |  | **FASD** | **☐** |
| **Learning Disability** | **☐** |  | **Medical Condition** | **☐** |  | **Grief/Loss**  | **☐** |
| **Anger/Aggression** | **☐** |  | **Pregnant/Teen Mom** | **☐** |  | **ADHD** | **☐** |
| **Parent/Teen Conflict** | **☐** |  | **Family History of Mental Health** **Family History of Addictions** | **☐****☐** |  | **Depression****Anxiety** | **☐****☐** |
| **Self-Harming** | **☐** |  | **Suicidal** | **☐** |  | **Abuse/trauma** | **☐** |
| **Medical Condition** | **☐** |  | **Autism Spectrum Disorder** | **☐** |  | **Other** | **☐** |
|  |

|  |
| --- |
| **Please provide further information surrounding the checked boxes:** |
|  |

|  |
| --- |
| **ADDITIONAL INFORMATION:** |
| **Is this youth currently working with any other professionals?** | **Yes** [ ]  | **No** [ ]  |
| **Names of the Counsellor(s):** |  |
| **Please indicate if there is any above information that you don’t want shared with the youth.****Comments:** |

If you have any questions or concerns, please feel free to contact Kelly Stewart at (250) 869-7156 or 763-2977 ext. 123 or email kstewart@arcprograms.com