ROBSON VALLEY COMMUNITY SERVICES

EXTERNAL - THIRD PARTY* - REQUEST FOR SERVICE

*Third Party might include Northern Health, School District, or another 3rd Party

Client Name:		**DOB (dd/mm/yyyy):**
Cell Phone:	**Work Phone:**	**Home Phone:**
Email:		**Gender:**
Home Address of Client:		
Mailing Address of Client (If different):		
Client's Emergency contact name:		**Phone:**
Relationship to client:		
Permission and safe to contact Emergency Contact during an emergency? ☐ **yes** ☐ **no** **If no, explain details:**		
Is it safe to contact client at home location? ☐ **yes** ☐ **no** **If no, where can contact be made:**		
Does the client know you are making this referral? ☐ **yes** ☐ **no** **If no, please explain:**		
Please specify the reason for referral, give as much detail as possible:		
Please specify what services you expect the client to receive from the agency and why:		
Does the client know the above reason for referral? ☐ **yes** ☐ **no** **If no, please explain:**		
Has the client given written consent for this referral?: ☐ **yes** ☐ **no** **If yes, please attach documentation of consent.** **If no, was verbal consent given by the client?:** ☐ **yes** ☐ **no**		
If client is under under 16* please indicate the name of the parent/guardian giving consent: ***In accordance with the Infant Protection Act of BC, minors 12 or older can request service without parental/guardian approval***		
Client's School (if applicable):		
Name of Person Making this Referral:		
Institution Making this Referral:		
Mailing Address:		
Phone:	**Fax:**	**Email:**
Do you require a follow up: ☐ **yes** ☐ **no**	**Preferred Method for Follow Up:**	
Frequency at which you require a follow up?		
Do you have any health or safety concerns you'd like your worker to know? ☐ **yes** ☐ **no** **If yes, explain details:**		
Client's previous evaluation, services, or treatment:		

Did you receive assistance filling out this form? ☐ yes ☐ no **If so by whom?**	**Name:** **Relationship to Client:**

Administrative Use Only:

Referral Received/Accepted Date (dd/mm/yyyy):	**If not accepted, why?**
Disposition:	**Date (dd/mm/yyyy):**
Scheduled Intake Date (dd/mm/yyyy):	**Contact Attempts:**

Check ☑ appropriate program intake/referral:

☐ PEACE	☐ STV Counselling	☐ Safe Shelter	☐ STV Outreach
☐ CYMH	☐ Victim Services	☐ Infant Development	☐ Sexual Assault Response
☐ Employment	☐ Family Support	☐ Child Development	☐ Men's Support
☐ Other RVCS Internal:		☐ Other External:	

Referral Taken By (name of staff):	**Date (dd/mm/yyyy):**
Approval of RVCS Supervisor/Manager:	**Date (dd/mm/yyyy):**
Staff Notes:	**Manager Notes:**

*This form has been adapted from Summers, N.(2009) Fundamentals of Case Management: Skills for Human Services, 5th Edition, Cengage: Boston