YOUTH RESOURCE CENTRE INTAKE

REFERRAL DATE (DD/MM/YYYY): _____

Referral Type (FOR MCFD/FVACFSS ONLY):

☐ Protection (MCFD/FVACFSS file to stay open) ☐ Non-protection (open file)

☐ Protection (MCFD/FVACFSS file to be closed) ☐ Non-protection (closed file)

Court Order # (if applicable): _____ **Court Service #** (if applicable): _____

**this information will be shared with the family

YOUTH AND FAMILY INFORMATION

Youth First Name: _____ **Youth Last Name:** _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Gender Fluid ☐ Other

Preferred Pronouns: _____

Birthdate (DD/MM/YYYY): _____ **Age:** _____

Contact Number: _____

Email: _____

Address: _____

Primary Spoken Language:

Indigenous: ☐ Yes ☐ No **Status:** ☐ Yes ☐ No **On Reserve:** ☐ Yes ☐ No

Band Name: _____

Current Living Arrangements: _____

Duration: _____

CAREGIVER INFORMATION

Caregiver Name: _____ **Relationship to Youth:** _____

Contact Number: _____

Email: _____

Address: _____

Caregiver Name: _____ **Relationship to Youth:** _____

Contact Number: _____

Email: _____

Address: _____

2420 Montrose Ave | Abbotsford, BC V2S 3S9
PH: 604-870-4YRC | **FAX:** 604-850-0731 | **WEBSITE:** www.yrc.ca
EMAIL: infoyrc@abbotsfordcommunityservices.com

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CHILDREN/YOUTH INVOLVED (fill in table below):

Name	Age	Relationship

SCHOOL AND COMMUNITY INFORMATION

Is youth/child attending school? ☐ Yes ☐ No **Current Grade:** _____

Name of school: _____

Contact person at school: _____

Contact Number: _____

Is the youth /child connected to any other agencies/professionals/support services? ☐ Yes ☐ No

If yes, please list: _____

Contact Name: _____ **Contact Number:** _____

REFERRAL SOURCE

Referred by: _____ **Relationship to Client:** _____

Agency: _____ **Position/Team:** _____

Phone: _____ **Email:** _____

Fax: _____ **Service Requested:** _____

REQUESTED SERVICE

Reason for Referral:

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Goals for this client:

Strengths:

Needs (if required)**:**

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YOUTH RESOURCE CENTRE INTAKE

Barriers:

RISK FACTORS

ALCOHOL USE ☐ NO ☐ YES _____

DRUG USE ☐ NO ☐ YES _____

CRIMINAL CHARGES ☐ NO ☐ YES _____

PERSCRIBED MEDICATIONS ☐ NO ☐ YES _____

ABUSE ISSUES ☐ NO ☐ YES _____

GANG INVOLVEMENT ☐ NO ☐ YES _____

MENTAL HEALTH ☐ NO ☐ YES _____

SUICIDE IDEATION/ATTEMPTS ☐ NO ☐ YES _____

VIOLENCE TO ☐ SELF
☐ OTHERS ☐ NO

OTHER ☐ NO ☐ YES _____

ADDITIONAL COMMENTS:

Caregiver Signature: _____ **Date:** _____

Caregiver Signature: _____ **Date:** _____

Youth Signature: _____ **Date:** _____

Referring Worker's Signature: _____ **Date:** _____

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