



Battlefords Concern for Youth Inc.
Connections Referral Form

Child's Name: _____ **Age:** _____ **Date of Birth:** _____

Preferred Name(s): _____ **Ethnicity:** _____

Parent/Guardians (List all caregivers that apply)

Name: _____ **Address:** _____

Email: _____ **Phone:** _____ (home) _____ (work)

Name: _____ **Address:** _____

Email: _____ **Phone:** _____ (home) _____ (work)

Emergency Contact Name: _____ **Phone:** _____

Physical Residence of child: _____

Summary of people in the home with child: (List extended family, boarders, siblings, cousins, etc.)

Family Composition: (add additional page if required)

Name: _____ **Age:** _____ **Relationship to child:** _____

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Name: _____ **Age:** _____ **Relationship to child:** _____

Name: _____ **Age:** _____ **Relationship to child:** _____

Name: _____ **Age:** _____ **Relationship to child:** _____

Name: _____ **Age:** _____ **Relationship to child:** _____

Is there anyone who may oppose this referral? _____ Yes _____ No. If yes, who and why?

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Referral Contact Name: _____ Phone: _____

Email: _____ School: _____

Other school contacts: _____

Reason for Referral:

List other Agency and supports involved:

Provide any additional information you feel is relevant (specific safety concerns, diagnosis, medications, allergies, etc.)

Date Received: _____

Date Reviewed: _____

Parent/Guardian Consent to Participate:

Print Name: _____ *Signature:* _____ *Date* _____

Print Name: _____ *Signature:* _____ *Date:* _____

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