OUTREACH THERAPY FAMILY CONNECTIONS PROGRAM
Early Childhood Mental Health Program
4325 Neill Street, Port Alberni, B.C. V9Y 1E5
Phone: 250-723-1117 Fax: 250-723-7349
E-mail: programs@outreachtherapy.org

Extended Therapy Services Form For Children age 7-12 years

DATE OF REFERRAL: _____ / _____ / _____
Day Month Year

NAME OF CHILD: _____, _____
(Legal Last Name) (First Name)

Birthdate: _____ / _____ / _____ **Gender**: _____
Day Month Year

Parents: _____ **Legal Guardian:** _____
_____ **(**If Applicable**)** _____

Address: _____ **Address:** _____

City: _____ **City:** _____

Postal Code: _____ **Postal Code:** _____

Home Phone: _____ **Phone:** _____

Cel Phone: _____ **Alternate Phone:** _____

Email: _____ **Email:** _____

Other Services / professionals involved with your child: _____

_____

Has your child received previous counseling ☐ **Yes** ☐ **No**

Reason for Referral: (Please provide brief description for reason of referral. If more space is needed, please add an extra page)

_____

_____

_____

Does child currently have access to funding for clinical counselling? ☐ **Yes** ☐ **No**

Please indicate funding source: _____

Has Parent been informed of the referral: ☐ **Yes** ☐ **No**

Okay to leave message on parent answering machine: ☐ **Yes** ☐ **No**

Referred By: _____

Agency / Profession: _____

Telephone: _____ **Email:** _____