



# MCFD Referral to Yellowhead Community Services Family Group Conferencing Program

612 Park Drive, Clearwater, BC, V0E 1N1  
Phone: 250-674-2600 Fax: 250-674-2676

**Person referred:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Agency:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Family member(s):**

| Last name: | First name: | Relationship: | DOB: |
|------------|-------------|---------------|------|
|            |             |               |      |
|            |             |               |      |
|            |             |               |      |
|            |             |               |      |
|            |             |               |      |
|            |             |               |      |
|            |             |               |      |
|            |             |               |      |

**Do any of the family member's identify as Indigenous?**                      Yes                      No

**Referred person's address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Alternate:** \_\_\_\_\_

**Reason for referral:**

Please describe in detail the family's present situation and attach any additional information.

---



---



---



---



---

**Child safety concerns:**

Please describe and include any upcoming court dates and/or orders:

---



---

---



---



---

**Social Worker and family's goals for meeting:**

---



---



---



---

**Additional information/comments:**

(ie. relevant history, health & safety concern, service requests, situations requiring immediate notification, etc)

---



---



---



---

**Significant extended family and/or friends involved:**

| Last name: | First name: | Relationship: | Contact info: |
|------------|-------------|---------------|---------------|
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |

**Other key participants in the planning, including professionals:**

| Last name: | First name: | Relationship: | Contact info: |
|------------|-------------|---------------|---------------|
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |
|            |             |               |               |

**Signature of referral source:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Referrals are to be faxed directly to the YCS FGC Coordinator at 250-674-2676 for review.  
Please contact the FGC Coordinator with any further information, questions or concerns regarding service delivery.*

