Intersect
Youth & Family Services

1294 Third Ave
Prince George, BC V2L 3E7
Phone: 250-562-6639
Fax: 250-562-4692

FAMILY-TEEN MEDIATION REFERRAL

Referral Date: _____

Self Referral? ☐ Yes ☐ No If no, Referral Source: _____

Referral Name: _____ Position/Role: _____

Office Phone: _____ Cellular Phone: _____

Email: _____ Fax: _____

Family Requesting Service

Parent/Guardian's Last Name: _____ First Name: _____

Preferred Name: _____

Gender: _____ Pronouns: _____ Do you Identify as Indigenous? ☐ Yes ☐ No

Street Address: _____ Postal Code: _____

Phone: _____ Email: _____

Preferred method for initial contact: ☐ Phone ☐ Email

Parent/Guardian's Last Name: _____First Name: _____

Preferred Name: _____

Gender: _____ Pronouns: _____ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)

Street Address: _____ Postal Code: _____

Phone: _____ Email: _____

Preferred method for initial contact: ☐ Phone ☐ Email

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Primary Youth Accessing Services:

Youth's Last Name: _____ First Name: _____

Preferred Name: _____ Age: _____ DOB: _____

Gender: _____ Pronouns: _____ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)
Street Address: _____ Postal Code: _____

Phone: _____ Email: _____

Preferred method for initial contact: ☐ Phone ☐ Email

Other Youth (12 yrs & Older) in Home/Family:

Youth's Last Name: _____ First Name: _____

Preferred Name: _____ Age: _____ DOB: _____

Gender: _____ Pronouns: _____ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)
Street Address: _____ Postal Code: _____

Phone: _____ Email: _____

Preferred method for initial contact: ☐ Phone ☐ Email

Youth's Last Name: _____ First Name: _____

Preferred Name: _____ Age: _____ DOB: _____

Gender: _____ Pronouns: _____ Do you Identify as Indigenous? ☐ Yes ☐ No

(If different from above)
Street Address: _____ Postal Code: _____

Phone: _____ Email: _____

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General Information

Please note that this service is voluntary! It is important that all members listed on this form are aware of this opportunity & are willing to meet with the Mediator to learn about this service and how it might support positive changes in the family/relationships. ***The caregiver and/or youth must provide consent at the end of this referral for it to be accepted for Family Teen Mediation services***.

Reason for Referral:

What is the youth and caregivers are hoping for as an outcome?

Is there a MCFD Social Worker supporting youth or caregivers? ☐ Yes ☐ No
If yes, please provide their name and contact information:

Current Custody/Access Situation:

Other Professionals/Agencies Providing Service to Youth or Caregivers?

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Are there any special service considerations we should be aware of to support this family? (Barriers, fears, disabilities etc.)

Are there any health care needs we should be aware of? (Allergies, diagnosis, recent hospitalization)

Is there any additional information we should be aware of at this time?

As the referring person, it is understood that the family being referred must sign or provide verbal consent before this referral is submitted to Intersect Youth and Family Services' Family-Teen Mediation program. If verbal consent given – please note below:

As a member of this family being referred, I/we support this referral being submitted to the Family-Teen Mediation program. I am aware this service is entirely voluntary and that the program will contact me once the referral is accepted but it is my responsibility to follow through with accessing services.

Youth	Caregiver/Guardian	Caregiver/Guardian

Note if verbal consent was given & by whom: _____

Please fax completed referral form to 250-562-4692, Attention: Family-Teen Mediation Program