Nuu-chah-nulth Teechuktl (Mental Health) Referral Form

Child & Youth Mental Health/Clinical Counselling/Quu'asa Wellness

Port Alberni Fax: 250-724-5747 Tofino Fax: 1-250-725-2158 Gold River 250-283-2122

Part One: Client Information	
Date of Referral	
Client's Name:	**DOB:**
If Youth – Caregiver name/relationship:	
☐ Male ☐ Female ☐ 2SLGBTQQIA+	
First Nation Affiliation	
Address:	**Client's Telephone #:** Is it OK to leave a message at this number? Yes / No Is it OK to send a **text** to this number? Yes / No

Part Two: Referral Information

Reason for Referral/Concerns/Presenting issues:

Is the client receiving any other services/supports/counselling that you are aware of?

Part Three: Referral Source

Referral Source Name:	**Referral Source Phone Number:**
Documentation / Reports Attached? ☐ Yes ☐ No	

Has the client/caregiver been informed & give consent to be contacted by Teechuktl Quuasa? ☐ Yes ☐ No

Client Signature: _____ or Verbal Consent ☐

For Office Use Only	**File #:**		
Referred to Teechuktl Quuasa: ☐ Clinical Counsellor ☐ Quuasa Wellness ☐ CYMH Name of worker referred to:	Accepted onto caseload ☐ Yes ☐ No	Date of 1st contact	**Or**: Referred to following outside agency: