WEECHI·IT·TE·WIN
Family Services Inc.

P.O. Box 812
Fort Frances, ON
P9A 3N1

Phone:1-807-274-3201
Fax:1-807-274-8336
Toll-Free:1-800-465-2911

Clinical Services Referral

FIRST NATION COMMUNITY: _____

DATE OF REFERRAL: _____

SERVICE BEING REQUESTED:

WFS PSYCHOLOGICAL SERVICES

☐ Comprehensive Psychological Assessment

☐ Psychoeducational/Psychometric Assessment

☐ Psychosocial Assessment

☐ Developmental Assessment

☐ Other:

WFS CLINICAL SERVICES COORDINATOR SERVICES

☐ Clinical Support/Training & Capacity Building

☐ Crisis Response

PROFESSIONAL CONSULTANT REQUESTED: _____

REFERRAL INFORMATION:

First Name: _____ Last Name: _____

Anishinaabe Name: _____ Clan: _____

Gender: ☐ Female ☐ Male ☐ LGBTQ2S Band Number: _____

Dob (D/M/Year): _____ Age: _____

CLIENT STATUS:

☐ Customary Care ☐ Family Support ☐ Residential ☐ Society/Crown Wardship

FAMILY INFORMATION:

Parent(s) Name: _____ Parent(s) Name: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Foster or Caregiver Name: _____ Legal Guardian Name: _____

Telephone: _____ Address: _____

Telephone: _____

SCHOOL INFORMATION:

Name of School: _____ Grade: _____

Telephone: _____ Primary contact: _____

MANDATORY DOCUMENTATION	IS IT INCLUDED?		
Document Needed	**Yes**	**No**	**N/A**
CR01 CR02			
Client Social History			
Previous Psychological Assessments			
Previous Educational Assessments			
Reports Cards			
Previous Telemental Health Reports			
Previous Assessment Tools/Screenings			
Consent to Release Information			
Genogram (Can also be in Social History)			

REASON FOR REFERRAL:

BRIEF DESCRIPTION OF PRESENTING PROBLEM AND/OR WHY TYPE OF SERVICE IS BEING REQUESTED:

DESIRED OUTCOME:

CLIENTS STRENGTHS AND GIFTS:

Referring CCP worker (print): _____ Signature: _____

CCP Supervisor (print):_____ Signature: _____

INTERNAL:

_____ _____

Clinical Services Coordinator Date

Name of Approved Consultant:_____

Consultant Notified (date): _____