WEECHI·IT·TE·WIN
Family Services Inc.

Nanaandawewenin Family Counselling Unit Referral Form

The WFS Family Counsellor program does not duplicate or replace services being funded and provided at each of the 10 First Nations. The primary duties of the WFS Family Counsellors are to provide intensive counselling services to children, youth, and their families who have multiple or complex needs. Family Counsellors may alternatively provide case consultations, recommendations about various resources as alternatives to counselling and/or support to Community Care Program Family Counsellors. Children and youth who may be referred to WFS Family Counsellors include, but are not limited to, those in care, those living with their biological parents, those living within a First Nation community, those who do not live within a First Nation Community, as well as any students in the Rainy River District school boards who are experiencing mental or behavioural health issues. Please be aware that parent/caregiver participation is essential to the counselling process and the healing of your family.

Client Name:	Referral Date:
D.O.B (M,D,Y):	File #:
First Nation:	Band Number:
Phone Number:	E-mail:
Client Mailing Address:	
	Street/Box: Town: Province: Postal Code:

Does the client/family's First Nation currently have a Family Counsellor on staff? ☐ Yes ☐ No

Is the child or youth currently in care with WFS or another child welfare agency? ☐ Yes ☐ No

Please list all other service providers currently involved with this client. (Please include service provider's name as well as the agency/organization they represent)

_____

_____

_____

_____

_____

Legal Guardian:

_____

Name Relationship

_____

Phone/Fax # Email Address

Caregiver: (If different from above)

Name | Relationship

Phone/Fax # | Email Address

Referral Source: (Case Worker)

Name | Agency Name/First Nation

Phone/Fax # | Email Address

Is the child or youth aware that you are making this referral and the reasons why? ☐ Yes ☐ No

If you answered "NO" please explain the reason: _____

Service Type Requested:

- ☐ Resource Recommendation
- ☐ Case Consultation
- ☐ Direct Intervention Support to CCP/FC
- ☐ Supportive Counselling
- ☐ Other:

Reason for Referral (Please provide specific details with regard to the nature of the issues you hope to resolve through counselling.)

Immediate Strengths and Needs:

Please attach any other important information/documentation and check box below:

- [ ] CR01-CR02
- [ ] Client's Social History
- [ ] Previous Psychological Assessments
- [ ] Previous Educational Reports/Assessment
- [ ] Previous Tele-mental Health Consult Reports
- [ ] Other Assessments/Screens
- [ ] Consent to Release Information
- [ ] Family Genogram

Client:	Date:
Client Guardian:	Date:
Worker:	Date:
Supervisor:	Date:

*please ensure all relevant parties have reviewed and signed prior to submission of this referral