Touchstone Family Association
Strengthening Family • Building Community

Connect Parent Group - Referral Form

Client Information:

Name
_____ Sex: _____
Address
_____
City/Town Prov. Postal Code
_____
Telephone (Home) (Work) (Cell)
_____
Date of Birth:
_____
Family Members: (if applicable)
_____

Parent/Guardian/Next of Kin Contact Information:

Name Please check: ☐Mother ☐Father ☐ Spouse ☐ Other:_____

_____
Address (if different from above)
_____
City/Town Prov. Postal Code
_____
Telephone (Home) (Work) (Cell)
_____

Referral Source: Please check if Self-referral ☐ If external referral, please complete:

Name
_____
Address
_____
City/Town Prov. Postal Code
_____
Telephone (Work)
_____

Have you discussed the referral with the family?
☐Yes ☐No

Please complete Page 2.....

Touchstone Family Association
Strengthening Family • Building Community

Reason for Referral
Please Describe:

What would you like to accomplish while receiving support from Touchstone Family Association?

Have you sought help for this problem before? ☐ Yes ☐ No
If yes, what services were received & how well did they work?

Are there other agencies involved (past or present)?
Please specify:

Additional Comments:

Signature & Date of Referral:
Please sign: Date:

Please return completed forms to either:

Daphne Meyer-MacLeod
Clinical Counsellor, FASD Key Worker
DMeyer@touchfam.ca PH: 604.207.5044

Jeff Markusoff
Registered Clinical Counsellor
JMarkusoff@touchfam.ca PH: 604.207.5057

Touchstone Family Association
210 – 3031 Viking Way
Richmond BC V6V 1W1