BRIDGES
FAMILY PROGRAMS

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477 3rd St SE
Medicine Hat, AB
T1A 0G8
bridgesfamilyprograms.com

REFERRAL FORM

Parent/Guardian Names:	**1.**	**Date of Birth** (DD/MM/YYYY):
	2.	**Date of Birth** (DD/MM/YYYY):
Telephone: **Alt. Telephone**:	**Text or leave message:** ☐ **Yes** ☐ **No**	**Prenatal Due Date** (DD/MM/YYYY):
Address:		
City:	**Postal Code**:	**Email**:

Child Name(s)	**Date of Birth** (DD/MM/YYYY)

Date of Referral:

Referral Source:

Contact Person:

☐ **N/A** **Phone Number**:

Information Taken by:

Primary Language in Home:

Interpreter Required? ☐ **Yes** ☐ **No**

Does the parent/guardian give Bridges Family Programs (BFP) permission to coordinate services within Bridges Family Programs to best meet family's needs? ☐ **Yes** ☐ **No**

Are parents aware of this referral? ☐ **Yes** ☐ **No**

☐ **Parents/guardians consented to the exchange of information between BFP and the Referral Source**

☐ **Parents/guardians did not consent to the exchange of information between BFP and the Referral Source**

☐ **Not applicable**

☐ **Follow up with Children's Services staff**

Identified family needs and reason for referral (I.e. risk factors, assists with triage):

Community supports/services currently involved with family:

Are there any safety concerns we should be aware of before meeting with the family? (Eg. History of violence, firearms/weapons in home, pets, food allergies, custody issues, substance use, etc.):

Please explain:

Program assigned *(office use only)* _____

Forms can be sent via email (preferred) to chok@bfpa.ca / admin@bfpa.ca or via fax to (403) 504-2459