



P: 403.526.7473
 TF: 1.888.756.7473
 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: | Text or leave message: | Prenatal Due Date (DD/MM/YYYY): |
| Alt. Telephone: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 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 amckinley@bfpa.ca / admin@bfpa.ca or via fax to (403) 504-2459