Strongest Families Referral Form

Fax to: 1-866-470-7222

Email to: faxes@strongestfamilies.com

Please Print

Child's Name: _____ **D.O.B.:** _____ **Sex:** _____ **H/C #:** _____

Parent/Legal Guardian Name: _____

Phone #: _____ (home) _____ (cell)

Best days/times to call to book an apt.: _____ **Email address:** _____

Parent/Youth Mailing Address: _____ **Postal Code:** _____

Referring Clinician/Physician : _____ **Clinic:** _____

Phone #: _____ **Fax #:** _____ **(PLEASE INCLUDE IF YOU WOULD LIKE CORRESPONDANCE)**

Child/Youth main presenting problem:

- ☐ **Behaviour (3-12 years)**
- ☐ **Anxiety (6-17 years)**
- ☐ **ICAN Adult Anxiety (18+ years)**
- ☐ **Nighttime Bedwetting (5-12 years)**

Additional information about the family:

- ☐ **French Speaking Family**
- ☐ **Military Family**
- ☐ **Split family;** Details: _____
- ☐ **Other:**_____

Criteria	SEND	DO NOT Send
Behaviour Program (ages 3-12) **Anxiety Program (ages 6-17)** **ICAN Adult Anxiety Program (18+)** **Nighttime Bedwetting (ages 5-12)**	√	
Significant symptoms ≥ 6 months **AND** **Significant impairment** (child/youth or parent/family)	√	
Can commit to weekly phone sessions over the next 4-5 months	√	
Active psychosis or primary depression		**x**
Imminent risk of harm to self/others and/or active suicidal thoughts		**x**
Past suicide attempt(s)		**x**
Substance use (causing significant impairment)		**x**

Some exceptions may be applicable. You can communicate any referral questions to Naomi LeBlanc, Evaluation & Bilingual Services Manager (nleblanc@strongestfamilies.com). Children who are at imminent risk or have significant cognitive impairment would not fit our entrance criteria.

CONTACT 1-866-470-7111
info@strongestfamilies.com
Website: www.strongestfamilies.com