These programs are for families that are affected by parental mental illness or substance use.
All programs are free of charge. For more information, please visit our website supportingfamilies.ca

Referral Form

REFERRAL SOURCE

Name (First Name, Last Name)	Role	Phone/Email

FAMILY CONTACT INFORMATION

Primary contact name(s): ____

Address: ____

Alternate address (if applicable): ____

Home phone #: ________________________ Is it OK to leave a voicemail? Y__ N __

Cell phone #: __________________________ Email: _________________________________

Preferred way(s) of contact (check the ones that apply): __ Home phone; __ Cell phone; __ Email

Best time to contact: ______________________ Do they know they have been referred? Y__ N__

FAMILY MEMBERS

	First Name	Last Name	Relationship	Age/DOB
Main Client	_________________	_________________	________________	___________
	_________________	_________________	________________	___________
	_________________	_________________	________________	___________
	_________________	_________________	________________	___________
	_________________	_________________	________________	___________

REASON FOR REFERRAL

We want to know how we can best support this family. Please tell us why you have referred this family, and what you hope they will gain from our programs:

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Thank you for your referral. We will be in contact with you soon.

Please send form to: Supporting Families
Tel: (604)782-1306 Fax: (604) 270-9245
info@supportingfamilies.ca