Interior Community Services
Enriching Lives, *Strengthening Communities*

FILE NUMBER _____

FAMILIES FIRST REFERRAL FORM

It is essential you fill out all fields of referral form

CRITERIA FOR REFERRAL AND ACCEPTANCE INTO THE PROGRAM:

*Pregnant – 32 weeks gestation or parenting an infant under 6-months of age

*1ST Time parenting experience

*1 or more risk factors: Low income, social isolation, mild to moderate mental health concerns or lack of supports

Parent's Name _____ DOB _____

Parent's Pronouns: _____

Address _____ Postal _____

Phone: _____

Co Parent's Name if applicable _____ DOB _____

Co Parent's Pronouns: _____

Address _____ Postal _____

Phone: _____

Is parent Pre-Natal? _____ If Yes Due Date _____ If no Infants DOB _____

Infants full name: _____ Assigned Sex _____

Marital Status _____ Low income _____

Housing Concerns _____ Current MCFD/SECW Involvement _____

Isolated _____ Mental Health Concerns _____

Disability _____ Specify _____ Violence Concerns _____

Substance Use Hx ___ Pre-Natal _____ Current _____

Additional Information _____

_____

Referring Person _____ Agency _____ Phone _____

Referral Date _____ Parent(s) are aware of referral _____

E mail referrals to: 396adm@interiorcommunityservices.bc.ca

Self-referrals accepted by calling 250-554-3134 ask for Families First Program

OFFICE USE ONLY:

Person Making Contact Date Time Message Left/Intake Date

_____

_____

_____

_____

Funded by the Ministry for Children & Family Development