MSS Direct Referral to Catholic Family Services – Counselling Services

This referral form must accompany a Support Services Contract from the Ministry of Social Services

Family Info

Mother: _____**DOB:**_____ **Father:** _____**DOB:** _____

Address: _____

Phone: **Mother (h)** _____ **May We Contact: Yes** ☐ **No** ☐

Father (h) _____ **May We Contact: Yes** ☐ **No** ☐

Other # (Mother) _____ **May We Contact: Yes** ☐ **No** ☐

Other # (Father) _____ **May We Contact: Yes** ☐ **No** ☐

Children's Names: _____ **Date of Birth:** _____

_____ _____

_____ _____

_____ _____

Other agency involved? Yes ☐ **No** ☐

If so, which ones? _____

_____

Are addictions, mental health or domestic violence an issue? Please explain.

_____

_____

_____

Are children in care? Yes ☐ **No** ☐ **If so, how long?** _____

Pertinent facts about family members (is child adopted, blended family, etc.)

_____

_____

Presenting Problem:

_____

_____

_____

Date of Referral: _____ **Referring Worker:** _____ **Phone:** _____

Primary Client (s): _____

Is client aware of referral? Yes ☐ **No** ☐