SOURCES
COMMUNITY RESOURCE CENTRES

BASIC REFERRAL

Referral Date (D/M/Y):		**Date of Birth**	
Client First Name:		Client Last Name:	
Funding Source	☐ AFU ☐ Home Schooling ☐Private Funds		
Gender:	☐ Male ☐ Female ☐ Non-Binary ☐ Intersex ☐ Two-Spirited ☐ Transgender ☐ Other		
Language Spoken:			
Cultural Background:			
Parent/Caregiver's names			
Phone # (Home):		Phone # (Cell):	
Address:			
Parent Email:			
CYSN Social Worker			

Therapy Options

We offer both in-home and center-based therapy for clients enrolled in our program.

1. What is your 1st preference?
   ☐ In-Home Therapy ☐Center Based Therapy ☐ Combination ☐ Virtual
2. What is your 2nd preference?
   ☐ In-Home Therapy ☐ Center-Based Therapy ☐ Combination ☐Virtual ☐None

Are there times that work best for 1-2 hour sessions?

Brief Description of Needs:

Send Referrals to: Email: pgcentre@sourcesbc.ca, fax: 250-561-1195

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