Vancouver CoastalHealth
Promoting wellness. Ensuring care.

DEAF WELL-BEING PROGRAM

CHILD REFERRAL FORM

Address: #300-4211 Kingsway, Burnaby BC V5H 1Z6
Phone Number: 604-456-0900
TTY Number: 6054-456-0901
FAX Number: 604-456-0904
Email: WellBeing.Staff@vch.ca

Today's Date (dd-mmm-yy): _____

Name of person completing this form: _____

Relationship with child (parent, GP, teacher, etc.): _____

Child Information (please print)

Last Name:_____ First Name:_____

Preferred Name:_____ PHN:_____

Date of Birth (dd-mmm-yy):_____ Age:_____ Gender: M☐ F☐ Transgender☐

Ethno/cultural Background:_____ Aboriginal: ☐Yes ☐No

Who does child live with (name & relationship)?_____

Address:_____
(Please include city and postal code)

Home Phone: _____ Can we leave a message/text at this number: ☐Yes ☐No

Family Physician:_____ Phone:_____

Child's Legal Guardian:_____Are they aware of this referral? ☐Yes ☐No

Parent Information

Last Name:_____ First Name:_____

Address:_____
(Please include city and postal code)

Home Phone:_____ Can we leave a message/text at this number: ☐Yes ☐No

Cell Phone:_____ Can we leave a message/text at this number: ☐Yes ☐No

Email:_____

Language

Deaf: ☐ Hard of Hearing: ☐ Deaf-Blind: ☐ Deafened: ☐

Preferred method of communication:_____

Past Support/Other People Involved

Has your child had counselling or mental health services before? ☐Yes ☐No

If yes, please tell us who provided the service and when:

_____

_____

_____

_____

_____

_____

Are there any other professions involved in supporting you (physician, social worker, other)? ☐Yes ☐No

If yes, please list:

Name: _____Phone:_____ Relation:_____

Name: _____Phone:_____ Relation:_____

Name: _____Phone:_____ Relation:_____

How can the Deaf Well-Being Program help you?

_____

_____

_____

_____

_____

For Office Only

Health Authority Region	**Last Name, First Name**	PARIS ID