

MSS Direct Referral to Rooted Connections – Counselling Services

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

Family Info

Mother: _____ **DOB:** _____ **Father:** _____ **D.O.B** _____

Address: _____

Phone: Mother _____

May We Contact: Yes No

Father _____

May We Contact: Yes No

Children's Names

Date of Birth

Other Agency Involved? Yes No

If so, which ones?

Presenting Problem:

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.)

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

Primary Client(s): _____

Is client aware of referral? Yes No

 306-525-0521

 160 McIntosh Street, Regina

 inquiries@rootedconnections.ca

 rootedconnections.ca