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**