AFNEA WELLNESS INITIATIVE

Referral for Wellness Services

Fields marked * are required. Complete what you can. You can still refer if unsure.

DALTON ASSOCIATES MENTAL HEALTH SERVICES

HOW TO SUBMIT THIS REFERRAL

WEBSITE:	Complete the online form at **afneawellness.ca/referral**
EMAIL:	Email the completed, password-protected PDF to **info@afneawellness.ca**. Please send the password separately.
IN PERSON:	Submit a completed paper form to AFNEA WI staff at the Education Office.
NEED HELP?	Email info@afneawellness.ca or message @afneawellnessinitiative on Facebook.

1. PERSON MAKING THE REFERRAL

Who is making this referral? *

◯ School Staff ◯ Parent/Caregiver ◯ Community/Program Staff ◯ Other

SELF-REFERRAL ◯ Child/Youth ◯ Adult helping a child/youth complete a self-referral

Name of person completing this form * _____ **Referral Date** _____

Organization/Program _____ **Role** _____

Contact information - Please provide at least one if available:

Phone _____ **Email** _____

Is a parent/caregiver aware that this referral is being made? * ◯ Yes ◯ No ◯ Not sure

Would you like confirmation that we received this referral? ◯ Yes ◯ No

2. CHILD/YOUTH INFORMATION

Full Name * _____ **Date of Birth** _____

Address _____

School ◯ KES ◯ VSS ◯ Other _____ **Grade** _____

Homeroom Teacher _____

Gender Identity ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Two-Spirit ☐ Prefer Not to Disclose

Language Spoken at Home ☐ Cree ☐ English ☐ Other _____

3. PARENT/CAREGIVER INFORMATION - OPTIONAL FOR SELF-REFERRALS

☐ Same as person making the referral - if checked, skip to **Section 4.**

Provide this information if available. It is optional for self-referrals. The service provider will explain whose permission is needed before services begin.

Full Name _____ **Relationship to Child/Youth** _____

Contact information - Please provide at least one if available:

Phone _____ **Email** _____

Can we leave a voicemail? ◯ Yes ◯ No **Can we email them?** ◯ Yes ◯ No

4. WHAT SUPPORT IS BEING REQUESTED? (CHECK ALL THAT APPLY)

DALTON CLINICAL SERVICES

☐ Counselling / Mental Health Support

☐ Behaviour Support (ABA)

☐ Speech-Language Pathology (SLP)

☐ Psychological / Learning Assessment

CULTURAL SERVICES

☐ Cultural Programming

Children and youth may self-refer for Counselling / Mental Health Support or Cultural Programming.

5. TELL US ABOUT THE REFERRAL

What would you like help with? *

Tell us what you can. It is okay if you are unsure or do not know how to explain what is needed.

Is the child/youth receiving support from anyone else right now? ◯ No ◯ Yes ◯ Not sure

If yes, what supports? _____

6. ANYTHING ELSE WE SHOULD KNOW? (OPTIONAL)