Counselling Program Referral Form

Thank you for reaching out to Dan's Legacy and helping connect youth with the resources and support they need.

Referral Guidelines

- To refer a client, please send this completed form to: Kathryn Priest-Peries, Program Manager, 778.896.3385, kathryn@danslegacy.com and copy Tom Littlewood, Program Director: tom@danslegacy.com
- All referrals are reviewed with our team at our weekly staff meeting and the assigned therapist will be in touch with the referred client the same week.
- Referring persons will be notified via email with the name of the assigned therapist and anticipated start date. Please note: any additional information sharing requires the client's consent.
- Some of our therapists have scheduled drop in days at our community partner locations and clients who may be in crisis and require help to stabilize the situation can be referred there. Therapists will follow the referral procedures and the client's information will be reviewed prior to assignment.
- While we cannot guarantee service, we will make every effort to make a great match for the client. We recognize a good relationship between the therapist and client is the best indicator for a successful outcome and may assign a client to another member of our team if required.

Referral Source Information

Name: _____ **Date of Referral:** _____

Agency/Relationship to Client: _____

Program/Department: _____

Phone: _____ **Email:** _____

Client Information

Client Name: _____

Address: _____

City: _____

Phone: _____ **Email:** _____

Are you able to travel to Surrey/New Westminster/Vancouver to see us? **Yes** ☐ **No** ☐

Dan's Legacy Foundation
5449 4th Avenue, Delta, British Columbia, V4M 1H2
www.danslegacy.com
CRA Registered Charity #84162 1154 RR0001

We respectfully and gratefully acknowledge that our work takes place on the unceded and traditional territory of the Coast Salish peoples

Parent/Guardian Name (if applicable): _____

Age: _____ **Ethnicity:** _____

Gender Identity: _____

Client Background (presenting issues, etc.):

Diagnosis (self or professional):

Prescribed medications and current/past substance usage:

Has client asked for specific therapist? **Yes** ☐ **No** ☐

If yes, please specify: _____

For more information or to make a referral, please contact:

Tom Littlewood, Program Director
604.999.9136, tom@danslegacy.com

Kathryn Priest-Peries, Program Manager
778.896.3385, kathryn@danslegacy.com

Internal Use Only

Referral Received Date: _____

Counsellor Assigned: _____ **Assigned Date:** _____

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