

 SAIP COUNSELLING (Sexual Abuse Intervention Program)

 1034 Austin Ave., 2nd Floor, Coquitlam, BC V3K 3P3 Tel: 604.937.7776 Fax: .604.937.7334

 203-11743 224th Street, Maple Ridge, B.C.  V2X 6A4 Tel: 604.463.0965 Fax: 604.463.2416

**SELF-REFERRAL FORM**

(For children and youth 18 y/o and under living in the Ridge Meadows or Tri-Cities communities)

 Referral Date:

Who referred you or how did you find us:

Client Name: D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Indigenous: Yes No

Person completing this form: Relation to client: \_\_\_\_\_\_

Name of Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is he/she aware of this referral? Yes No

If no, please indicate reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:

Home Phone: Is it OK to leave message? Yes No

Other Phone: Email: \_\_\_\_\_

If counselling is being requested for a child of separated or divorced biological parents, please complete the following 3 questions: N/A

1. Who has signing authority for the referred child(ren):

1. Is a court order available? Yes No Unsure N/A
2. Are Child Custody or Access Issues Present? Yes No If yes, please explain:

Has this incident been reported? Yes No Unsure N/A

OVER TO PAGE 2 …

Please briefly indicate the purpose of counselling and any other information you feel comfortable providing to us in relation to the concerns identified:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Once ACT 2 receives this completed form, a counsellor will reach out to you via the phone number(s) provided to set up an appointment for intake, followed by regularly scheduled weekly sessions on a day and time that works for both the client and counsellor.

The length of service for this self-referral counselling program is up to nine months.

Thank you.