CARRIER SEKANI FAMILY SERVICES

FAMILY JUSTICE REFERRAL FORM

Please send all complete referrals to familyjustice@csfs.org or fax 250.562.2272

TYPE OF MEDIATION REQUESTED (select one)

REFERRAL DATE:_____

- ☐ Traditional Decision Making
- ☐ Family Case Planning Conference
- ☐ Family Group Planning Conference
- ☐ Youth Transition Conference

CONTACT INFORMATION:

Has the family agreed to participate in meeting? ☐ Parent/caregiver ☐ Child(ren)

Social Worker:	
Phone:	
Email:	
Office Code:	
CS/FS/PO/CYMH #:	
Supervisor/ Team Leader:	
Phone:	

Child's Name	DOB	Band

Mother/Caregiver Name:	
Phone:	
Address:	
Band:	
Father/Caregiver Name:	
Phone:	
Address:	
Band:	

CARRIER SEKANI FAMILY SERVICES

OTHER PARTICIPANTS: (relatives, close friends, support people)

Name	Phone	Address	Relationship

BRIEF DESCRIPTION OF WHY CHILD & FAMILY SERVICES IS INVOLVED AND SITUATION TO BE ADDRESSED:

THIS SECTION FOR FAMILY GROUP CONFERENCING REFERRAL

DOES THE FAMILY WANT CLAN REPRESENTATION & INVOLVEMENT AT THE MEETING?

Mother's Clan: ☐ Yes ☐ No _____

Father's Clan: ☐ Yes ☐ No_____

PRIMARY REASON FOR REFERRAL:

☒ Safety Planning	☐ Permanency Planning
☐ Access/Relationship Issues	☐ Planning for Independence
☐ Placement Concerns	☐ Reunification with Family/Roots
Other:	

People who you determine are INAPPROPRIATE to participate:

Name	Reason