Caring Dads Referral Form

This referral is to be completed by the referring agent and be submitted to Langley Community Services Society fax number: 604-533-0020 or by email to msmiley@lcss.ca. Please contact Matthew Smiley for more information: Office phone: 604-533-7920 ext 1305 Cell: 604-440-9079 email: msmiley@lcss.ca.

Referring Agent Information:
Referral date: ________________ Referred by: __________________
Referring Agent contact information: Phone: Cell: __________________ Office: __________________
Email: ____________________ Fax: ___________________

Client Personal Information:
Client Name: ___________________ D.O.B Y/M/D________________ ☐ M ☐ F Other:_________________
Address: ______________________ Home phone: ________________ Cell: ________________________
Email: _________________________
Preferred way of communication Text: ☐ yes ☐ no Call: ☐ yes ☐ no Email: ☐ yes ☐ no
Okay to receive emails: ☐ yes ☐ no
Preferred Language: __________________
Special needs/disability: ______________________ ☐ yes ☐ no
Does client identify as Indigenous: ☐ Yes ☐ No
Marital status: Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Other ☐
Medications: ____
Children involved:
Name: ________________ D.O.B: Y/M/D___________________
Name: ________________ D.O.B:___________________
Name: _______________ D.O.B:___________________
Name: ________________ D.O.B:___________________

What programs are/have been the children been involved with:
____
____

Legal Matters:
Living with partner: _____________________________________
Contact with partner: ____________________________________
Contact with children: ___________________________________
Access to weapons: ______________________________________
Probation: ____
Criminal history:
____
____

Reason for Referral (what was the reason that led to domestic violence intervention?):
____
____
____
____
____

Barriers to service (please list any barriers this client may have to accessing and/or completing service):____
____
____

Past and/or current counselling programs involved in/with: _______________________________

please attach supporting documents pertaining to this client to the referral form (contact order information, parole information, medication information etc.)

Partner Personal Information:
Contact Partner □ Yes □ No
Clients Name: _________________ D.O.B: Y/M/D_______________ □ M □ F Other: ______________
Address: ______________________ Home phone: ________________ Cell: ______________
Email ________________________ Preferred Language:_______________________
Interpreter: □ Yes □ No
Does the client identify as Indigenous: □ Yes □ No

Other Services Accessed:
____
____

please attach supporting documents pertaining to this client to the referral form (contact order information, parole information, medication information, etc.)

Please sign below:

Referring Agent: ________________________ Date: _________________________
Client: __________________________ Date: __________________________
Caring Dads Facilitator: _________________________ Date: _____________________