SOUTH ISLAND WELLNESS SOCIETY (SIWS)

YOUTH TRANSITION REFERRAL FORM

This program is intended for Indigenous youth ages 16-18 who are currently accessing services from The Ministry of Child and Family Development and/or a Delegated Aboriginal Agency. The guidance and support provided is aimed to assist the Youth as they transition out of care and into adulthood. A Youth Coordinator will connect and work with the Youth to plan a Youth Transition Conference and achieve the goals they establish within it.

Please send this referral by e-mail to intake@siws.ca, or call us at 778-426-2997.

Referrer:	**Referral date**:
Contact Info:	*SIWS File #*
Referral Source: ☐ Community ☐ Self ☐ MCFD ☐ NIL/TU,O ☐ Surrounded by Cedar ☐ Hulitan ☐ Métis Community Services ☐ Victoria Native Friendship Centre ☐ Other:	
Urgency: ☐ Immediate (within 48 hrs) ☐ Moderate (5 business days) ☐ Low (10 business days)	

Youth (receiving transition services)

Name	(M/F/NB)	Legal status (If in care, how long?)	Date of Birth (mm/dd/yy)	Address	Contact information (Phone/E-mail)
Name: Band:					

Guardians/Caregivers

Name	Address	Date of Birth (mm/dd/yy)	Contact information (Phone/E-mail)
Guardian/Caregiver: **Band:** **Relationship to child:**			
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Community

Community where the family currently resides:
☐ Tsartlip ☐ Tsawout ☐ Tseycum ☐ Pauquachin ☐ Songhees ☐ Esquimalt
☐ T'Sou-ke ☐ Beecher Bay ☐ Pacheedaht ☐ Métis ☐ Urban *double click the box to check

Consent

Is the Youth already aware of this referral to SIWS?	☐ Yes ☐ No

Issue Statement

Briefly describe the Youth's situation and reason for requesting Youth Transition Services?

Band Designate / C.P.C. Contact / Social Development Contact

Name	Position

Significant Extended Family or Community Members Involved

Name	Relationship	Contact Info

Other Key Participants in the planning including professional services already involved

Name	Relationship	Contact Info

Youth Transition Advocate Assigned: Date: