



SOUTH ISLAND WELLNESS SOCIETY (SIWS) YOUTH TRANSITION REFERRAL FORM

This program is intended for Indigenous youth ages 14-21 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

Referrer:	Referral date:
Contact Info:	Email:
Referral Source: <input type="checkbox"/> Community <input type="checkbox"/> Self <input type="checkbox"/> MCFD <input type="checkbox"/> NIL/TU,O <input type="checkbox"/> Surrounded by Cedar <input type="checkbox"/> Hulitan <input type="checkbox"/> Island Métis <input type="checkbox"/> Victoria Native Friendship Centre <input type="checkbox"/> Other:	
Urgency: <input type="checkbox"/> Immediate (within 48 hrs) <input type="checkbox"/> Moderate (5 business days) <input type="checkbox"/> Low (10 business days)	

Youth (receiving transition services)

Name	Gender/ Pronouns	Legal status (If in care, how long?)	Date of Birth (mm/dd/yy)	Address	Contact Info (Phone/E-mail)
Name: Band(s):					

Guardians/Caregivers

Name	Gender/ Pronouns	Address	Date of Birth (mm/dd/yy)	Contact Info (Phone/E-mail)
Name: Band(s): Relationship to youth:				
Name: Band(s): Relationship to youth:				

Community

Community where the youth currently resides: *double click the box to check
<input type="checkbox"/> Tsartlip <input type="checkbox"/> Tsawout <input type="checkbox"/> Tseycum <input type="checkbox"/> Pauquachin <input type="checkbox"/> Songhees <input type="checkbox"/> Esquimalt
<input type="checkbox"/> T'Sou-ke <input type="checkbox"/> Beecher Bay <input type="checkbox"/> Pacheedaht <input type="checkbox"/> Urban

Consent

Is the Youth already aware of this referral to SIWS? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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	Contact Info (Email & Phone #)

Significant Extended Family or Community Members Involved

Name	Relationship	Contact Info (Email & Phone #)

Other Key Participants in the planning including professional services already involved

Name	Job/Organization	Contact Info (Email & Phone #)

Youth Transition Advocate Assigned:

Date: