

**Referral for Sexual Health Services  
SHADE Consulting and Counselling**

P.O. Box 22134, 144-1835 Gordon Drive, Kelowna, BC V1Y 3H0  
Phone: 778-215-0132 Email: info@shadeconsulting.ca

Referral Date:	
Referring Source:	
Address:	
Telephone:	Email:

**PLEASE COMPLETE IN FULL AND PRINT CLEARLY**

Client's Surname:	Given Name:	Middle Name:
Marital Status	Identifies as: Female: <input type="checkbox"/> Male: <input type="checkbox"/>	DOB (DD.MM.YY):
Client's Address:		
Phone:	Work Phone:	Email (if applicable):
Family Contact/Next of Kin:		Relationship:
Phone:	Work Phone:	Email:
Contact Person: (if different from family contact)		Relationship:

REASON FOR REFERRAL (What are the current issues/concerns prompting this referral?) Attach a separate sheet if more space is required.

Has the reason for referral ever led to arrest?	NO <input type="checkbox"/> YES <input type="checkbox"/>
Has the reason for referral ever led to conviction?	NO <input type="checkbox"/> YES <input type="checkbox"/>
If yes, is the client currently on probation?	NO <input type="checkbox"/> YES <input type="checkbox"/>
If yes, what are the conditions of the probation and when is it finished?	Date:
Probation officer:	Phone:



**PREVIOUS AND/OR CURRENT SERVICES:**

<input type="checkbox"/>	Developmental Disabilities Mental Health Services (please list psychiatrist & consultant)	Date:
<input type="checkbox"/>	Community Living BC (CLBC) (Please list facilitator)	Date:
<input type="checkbox"/>	Ministry for Children and Family Development (MCFD) (Please list social worker)	Date:
<input type="checkbox"/>	School District (which):  School (Current or most recent):  Grade (if current):  Program attended:  Current teacher:	Date:  Date:  Date:  Date:  Date:
<input type="checkbox"/>	Psychiatric care (Please list psychiatrist):	Date:
<input type="checkbox"/>	Behavioural Consultant (Please list any consultants):	Date:
<input type="checkbox"/>	Boundaries Program	Date:
<input type="checkbox"/>	Counselling (Please list any counsellors)	Date:
<input type="checkbox"/>	Art or Play Therapy (Please list any therapists)	Date:
<input type="checkbox"/>	Other (Please detail):	Date:

Please attach any reports thought to be pertinent for this referral (ex. Sunny Hill, psycho-educational assessments, safety plan, IEP's, etc.).

Please note: Services from SHADE Consulting Ltd. are fee for service. Clients will be expected to acquire appropriate funding before services will be delivered. Outside funding can **sometimes** be sought through some of the following sources or services through SHADE Consulting and Counselling can be covered by some of these funding sources. It is the responsibility of the client to ensure funding although SHADE Consulting and Counselling may be asked to provide a service proposal or quotation to appropriate funding sources.

- Autism Funding Unit (Province of BC)
- Community Living BC (CLBC)
- Ministry for Children and Family Development (MCFD)
- Children and Youth with Special Needs (CYSN – MCFD)
- Some extended health benefits will cover counselling services

For office use only:

Intake Date:	Number of Hours Approved:	
Hourly Rate:	Funding Source:	Bill To:
Service Agreement Done: <input type="checkbox"/> Yes <input type="checkbox"/> No		