Families Matter Society of Calgary
#158 1440 52nd Street NE Calgary, AB
Main : (403) 205-5178
Intake: (403) 205-5194
Email: intake@familiesmatter.ca

INDIVIDUALIZED FAMILY SUPPORT PROGRAM

Referral and Release of Information Form PLEASE PRINT LEGIBLY

Please complete ALL sections of this form, or indicate "N/A" for not applicable. We will be unable to process your referral without complete information.

Parent/Guardian Information

First Name:		**Last Name:**		**How Many Adults live in the household?**
Date of Birth: DD/MM/YYYY		**Age:**	**Indigenous: Yes No**	
Relation to Child:				
Street Address			**Apartment #:**	
City:			**Postal Code**	
Email:				**How many children live in the household?**
Home Phone:	**Work Phone:**	**Cell Phone:**		
Prenatal? Yes No	**Due date? DD/MM/YYYY**			

CHILD'S INFORMATION

Name of Child:	**First:**	**Last:**	
Date of Birth: DD/MM/YY		**Age:**	**Gender:**
Name of School:		**Grade:**	

Language primarily spoken at home:

English	Other (specify):

SIBLINGS

First Name	Last Name	Date of Birth	Gender	Lives with Child:

Reason for Referral (Describe specific, emotional, behavioral and mental health concerns)

Are you or have you ever been involved with community agencies, groups or programs (including Child and Family Services)?

☐ Yes ☐ No If yes, which ones? (Please List)

Name of Service	Purpose of Involvement	Date
1)		
2)		
3)		
4)		

Additional comments or concerns that would help to understand your situation.

Program/Agency Making Referral	Referring Staff Name	Position/Title

***Please Note: Email address must be provided to be informed of referral status (please print legibly)**
Families Matter will not fax referral status information to referring agencies.

*Referring Staff Email	Contact Phone Number

Consent to Release Information:

I,_____ authorize _____
(Print Client Name) *(Print Referring Staff Name)*

Or

I, _____ received verbal consent from _____
(Print Referring Staff Name) *(Print Client Name)*

to discuss or release information to Families Matter Individualized Support program for the purposes of referral and assessment.

Client Name:(please print)_____ **Client Signature:**_____

Date: DD/MM/YYYY _____