North Island Crisis & Counselling Centre

Early Years Family Navigator Program
9350 Granville Street – Box 2446
Port Hardy, BC V0N 2R0
Phone: 250-949-8323 email: sonjac@nicccs.org
Fax: 250-949-8344

REFERRAL FORM – Early Years Family Navigator

Referral Date: _____

Has parent/guardian/ family been informed and agreed to this referral? Yes □ No □

Family's Contact Persons: _____ or _____
Street Address: _____ PO Box# _____
City: _____Postal Code _____
Contact Number: _____home _____cell
Does Family Identify as Indigenous? YES NO

Preferred method of contact? Please circle all that apply.
Home phone Cell Phone Text Facebook (messenger) email

Family Members _____Age: _____ **Male** □ **Female** □
Family Members _____Age: _____ **Male** □ **Female** □
Family Members _____Age: _____ **Male** □ **Female** □
Family Members _____Age: _____ **Male** □ **Female** □
Family Members _____Age: _____ **Male** □ **Female** □
Family Members _____Age: _____ **Male** □ **Female** □

Reason for referral?

Support With:
□ Child Care placement and funding □ Accessing programs and Services □ Assistance with Forms
□ Parent/Child Relationship/Parenting Resources □ Support while transitioning after children return from care
□ Nutritional Programs □ Advocacy

□ Other *(please give brief overview)*
_____
_____
_____

For Office Use Only:

Initial contact _______________ Initial Visit _____ Consent for Service Completed ☐

Referral source: _____Agency:_____Ph:_____