The purpose of this document is to gather necessary information to briefly assess what the needs of the client are and determine if SOY programs are the right fit for them.

\*Required

Referrers Name, Organization, and Contact information\* Click or tap here to enter text.

Date of referral\* Click or tap to enter a date.

Name of client:\* Click or tap here to enter text. Date of birth:\* Click or tap to enter a date.

Client contact information:\* Phone Number Email

Reason for referral\*

Click or tap here to enter text.

1. Has the client ever been involved with a Children’s Aid Society?\* Yes  No
2. Which of the follow will the client be interested in working on? (choose all that apply)\*

|  |  |
| --- | --- |
| Mental Health  Addictions  Physical Health  Housing  Financial Planning  Life Skills  Employment  Education | Food Security  Transitioning  Relationship Issues  Racism and/or discrimination  Legal Issues  ID  Immigration and Settlement  Other Please specify |

1. Does the youth have or require a working safety plan? Yes  No
2. Is there anything else you would like to share or that is important for us to know to best support this client? Click or tap here to enter text.