



# AGENCY REFERRAL FORM

<b>Internal Use Only</b>	
Date Received at TRiP office: _____	Assigned TRiP ID: _____

11UI Referral:  **OR** twelve&up Referral:   
 (check only one)

Male: \_\_\_\_\_  
 Female: \_\_\_\_\_

It is suitable to make a referral to TRiP's 11UI or twelve&up initiative if you have detected behaviours or conditions that place a child/youth in a position of vulnerability. Elements to consider for a referral to TRiP are:

- The child/youth exhibits multifaceted behavioural challenges.
- The child/youth is showing or is affected by composite risk factors.
- Previous engagements in services have shown little progress in the child/youth.
- The child/youth has experienced personal, situational, and/or institutional barriers to services and support.
- After having explored other options, the referring agent considers TRiP to be the best option.

<p><b>IMPORTANT NOTE:</b> By completing this form, you are acknowledging that there has been an informed conversation with the client and caregiver about TRiP. You feel confident that you have gained their understanding regarding an opportunity for coordinated support through The Regina Intersectoral Partnership's 11UI or twelve&amp;up initiatives.</p> <p style="text-align: right;">if so, please INITIAL HERE: _____</p>
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This form will be used to gather the limited amount of information needed on a client to pursue the intake process.

<b>Date of Referral:</b>	
<b>Referring Agent Name:</b>	<b>Phone:</b>
<b>Referring Agency:</b>	<b>Email:</b>
<b>Describe agency role/relationship with the client:</b>	<b>Duration of relationship:</b>
<p><b>FOR SCHOOL REFERRALS ONLY</b></p> <p><b>Please list who from the school team support knows about and supports this this referral:</b></p> <p><input type="checkbox"/> School Counsellor</p> <p><input type="checkbox"/> Family Support Worker</p> <p><input type="checkbox"/> LRT / EA</p> <p><input type="checkbox"/> School Resource Officer</p>	

**Please return completed form to TRiP:**  
 (306) 523 3024 tripstaff1@gmail.com

<b>Child's Full Name:</b>		<b>Male/Female</b>	<b>Birthday:</b>
<b>Is child regularly attending school?</b>  __ Yes __ No		<b>Are parents involved in their child's school?</b> (e.g. volunteer, support activities, encourage attendance)  __ Yes __ No	
<b>Child's School:</b> <i>(if not attending, indicate reason)</i>		<b>Grade:</b>	
<b>Primary Caregiver Name:</b>		<b>Relationship:</b>	
<b>Caregiver Address:</b>	<b>Caregiver Phone:</b>	<b>Caregiver Email:</b>	
<b>Check the risk categories relevant to the referral of this individual to TRiP? please explain each</b>			
__ alcohol : _____			
__ drugs : _____			
__ gambling : _____			
__ mental health : _____			
__ cognitive impairment : _____			
__ physical health : _____			
__ suicide : _____			
__ self-harm : _____			
__ criminal involvement : _____			
__ crime victimization : _____			
__ physical violence victim : _____			
__ physical violence perpetrator : _____			
__ emotional violence victim : _____			
__ emotional violence perpetrator : _____			
__ sexual violence victim : _____			
__ sexual violence perpetrator : _____			
__ elderly abuse perpetrator : _____			
__ poor supervision : _____			

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- basic needs : \_\_\_\_\_
- missing school : \_\_\_\_\_
- parenting concerns : \_\_\_\_\_
- housing : \_\_\_\_\_
- poverty : \_\_\_\_\_
- negative peers : \_\_\_\_\_
- anti-social behaviour : \_\_\_\_\_
- unemployment : \_\_\_\_\_
- missing/runaway : \_\_\_\_\_
- threat to public safety : \_\_\_\_\_
- gangs : \_\_\_\_\_
- social environment : \_\_\_\_\_
- other (explain ) : \_\_\_\_\_

**What are some of the concerns that have led you to make this referral? (please explain)**

**That you are aware of, what agencies have PREVIOUSLY been involved in providing services or supports to this individual?**

- School counselor (if so, who? \_\_\_\_\_)
- School Resource Officer (if so, who - \_\_\_\_\_)
- Family Support Worker (if applicable)
- LRT / EA
- Child & Youth
- Autism Centre
- Family Service Regina
- Dreambroker
- Ministry of Social Services
- Regina Fire Department (prevention)
- Aboriginal Family Services
- Fox Valley
- Cognitive Disability

If there are others, please describe:

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**That you are aware of, what agencies are CURRENTLY involved in providing services or supports to this individual?**

- School counselor (if so, who? \_\_\_\_\_)
- School Resource Officer (if so, who - \_\_\_\_\_)
- Family Support Worker (if applicable)
- LRT / EA
- Child & Youth
- Autism Centre
- Family Service Regina
- Dreambroker
- Ministry of Social Services
- Regina Fire Department (prevention)
- Aboriginal Family Services
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If there are others, please describe:

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**Has the child/youth encountered any personal, situational or institutional barriers to support/services? (e.g. transportation, parental support, financial barriers)**

- personal
- financial
- transportation
- lack of parental support

If there are others, please describe:

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**To be completed by TRiP Referral & Intake Officer Only**

**Referral Received Date:** \_\_\_\_\_

Date/time caregiver contacted:

Verbal consent given:

Other Notes:

yes  no