Referral Form

Please check <u>one</u> of the following:

Youthreach (Males 12 – 17 yrs.) ☐

Self-Esteem Enhancement Development (SEED – Females 12 – 17 yrs.)☐

Referring Agency: _____ Date of Referral: _____

Agency Contact: _____ Telephone: _____ Fax: _____

Briefly outline how our group might be helpful to your client / child:

_____

_____

_____

_____

Youth's Name: _____ Age: _____ Date of Birth: _____

School: _____ Grade: _____

Youth's Address: _____

Postal Code: _____ **Phone:** _____

Parent or Guardian: _____ Relationship to Youth: _____

Parent or Guardian's Address & Phone Number if different from Youth's:

_____ Phone: _____

Please Return To: ***Community Organized Support and Prevention (Quinte)***
121 Dundas Street East, Suite 206
Belleville, Ontario
K8N 1C3
Contact: Stacey Scott ***(613) 966-7410 FAX (613) 966-7411***
Email: *sscott@cosp.ca*