Big Brothers Big Sisters of Toronto

Service Provider Referral Form

Referral completed by:

Date:______________________
mm/dd/yyyy

Referring Worker: ______________________________
First Name Last Name

Job Title: ______________________

Referring Organization/Institution____

Tel.#: (_____)_______________ Ext.: __________ Email:______________________

General Information

(Please Note:** For statistical purposes we are required to ask the following questions**)

Client Contact Information:

Child/Youth's Name:____
First Middle Last Name

Other Names: ____________________

Date of Birth: ____________________ Place of Birth: ______________________________

Home Phone: ____________________ Mobile Phone:______________________

E-mail:________________________ Business Phone:______________________

Preferred method of contact ☐ home phone ☐ Email ☐ Mobile ☐ Business

Preferred time of contact ☐ Morning ☐ Afternoon ☐ Evening

Address: ____
Apt. Street City Prov. Postal Code

Primary Caregiver Information:

Parent/Guardian Name: ____

If Guardian, please note relationship to child: ______________________________

Home Phone: ____________________ Mobile Phone:______________________________

Email: ________________________ Business Phone: ______________________________

Preferred Method of Contact ______________________ (home, mobile, business, email)

Primary Caregiver Address: ☐ Same as above Primary Caregiver lives with Child ☐ Yes ☐ No

Date of Birth: ____________________ Place of Birth: ______________________________

Ethnicity of the Parent: ____

Is this family considered a visible minority? ☐ Yes ☐ No ☐ Unknown

Is this family living in poverty? ☐ Yes ☐ No ☐ Unknown

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Referring Organization's Involvement

1. Date child/youth became involved with your Organization/Institution:____________________
   mm/dd/yyyy

2. Date child/youth terminated their involvement with your Organization/Institution: (if applicable):__________
   mm/dd/yyyy

3. Reason for involvement:
   ____
   ____

4. To the best of your knowledge, has the child/youth been diagnosed with any type of special need or developmental disability? If so, please explain:
   ____
   ____

5. To your knowledge, is the child/youth prescribed/administered medication? ☐ Yes ☐ No ☐ unknown
   If yes, please complete the following to the best of your abilities.
   Name of medication: ______________________________
   Reason for prescription:______________________________
   Length of time taken: ______________________________
   Is client currently on above medication? ☐ Yes ☐ No

6. To the best of your abilities, please list the child/youth's interests and strengths:
   ____
   ____

6. Based on your knowledge of this client, would any of the following conditions present as a risk while this client was spending time with his/her mentor? (Please check any/all that apply):

   - ☐ Child/Youth's ability to communicate verbally
   - ☐ Child/Youth's ability to form personal connections
   - ☐ Child/Youth's comprehension of safety principles
   - ☐ Child/Youth's ability to perform independent self-care (i.e. washroom)
   - ☐ Child/Youth has lived at current address for less than one year
   - ☐ Tendency to run away

   Additional Comments (if any):
   ____

7. Based on your knowledge, please select the following guidelines that the parent/guardian is able to fulfill: (Please check any/all that apply):

   - ☐ Parent/Guardian is able to communicate verbally
   - ☐ Parent/Guardian is able to coordinate outings with mentor regularly
   - ☐ Parent/Guardian is able to comprehend safety principles

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of Toronto

☐ Parent/Guardian is able to keep in regular contact with agency

Additional Comments (if any): ______________________________

7. On a scale of 1 – 10, please describe the child/youth's level of aggression: (please circle one)

1	2	3	4	5	6	7	8	9	10

(Least Aggressive) (Most Aggressive)

8. Volunteers often spend time in the community with children/youth unsupervised by BBBST staff. Knowing this, do you think this child/youth is well suited for the program and or do you foresee any risk management problems?

____
____
____

9. BBBST works closely with the child/youth and family throughout the match. Based on your interaction with the parent/guardian or family, do they have difficulty following through with scheduled meetings?

   ☐ Yes ☐ No

   Notes/additional comments:

____
____
____

10. Based on your interactions with the child/youth, do you have any recommendations for an ideal Big Brother/Sister? (Please feel free to add any information that you feel could assist us in gaining a better understanding of this child/youth/family)

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____
____

☐ B***y checking this box, the Service Provider confirms that Parent/Guardian has granted full verbal consent to share the above information with Big Brothers Big Sisters of Toronto to assist with the client's the intake process.***

Referring worker's Full Name:______________________________
First Last

Referring worker's Signature:______________________ Date: ______________
mm/dd/yyyy

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