Nanaimo Family Life Association

Healthy individual and family relationships are the heart of a strong and resilient community

Seniors Peer Counselling Referral/ Intake Form

Family Name:	First Name:
DOB:	Gender: ☐ Male ☐ Female
Marital Status:	Phone Number:
Address: City: Postal Code:	Contact Person: Phone Number:
Family Doctor: Phone Number:	Client aware of Referral: ☐ Yes ☐ No
Clients living conditions:	
Brief Medical condition relevant to referral:	
Limitation or disability relevant to referral:	
Social or Family circumstances relevant to referral:	
Reason for referral:	
What has been tried:	
Expectation or goal:	

**** This part is to be filled out by the Program Coordinator****

Report of Referral Outcome: Date: _____
Course Summary:

Intake by: _____ SPC assigned: _____

Review date: _____ Evaluation date: _____

Response: ☐ Yes ☐ No

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