A Reason to Hope. The Means to Cope.
British Columbia Schizophrenia Society
BC Schizophrenia Society Foundation
Supporting the BC Schizophrenia Society

Medical Advisory Board
Dr. Bill MacEwan, FRCPC
Dr. William G. Honer, MD, RCPC
Dr. Anthony Phillips, Phd., FRSC

Kids in Control & Teens in Control Referral Form

Referrer Information

Referrer: ____
Name *Agency (if applicable)*

Phone Number: ____________________ Email Address: ____________________

Participant Information

Name: ____
First *Last* *Preferred Name*

Birth Date: ____________________ Age: ____________________

Gender: ____

Name of Parent/ Guardian(s): ____

Address: ____
Street Address *Apartment/Unit #*

____
City *Postal Code*

Primary Phone: ____________________ Alternate Phone: ____________________

Email: ____

Family Member Living with Mental Illness: ____________________ Diagnosis (If known): ____________________

Participant's level of awareness of mental illness: ____

Independent Youth Information

Social Worker: ____

Phone Number: ____________________ Email Address: ____________________

1100 – 1200 West 73rd Avenue, Vancouver, B.C. V6P 6G5
Tel: (604) 270-7841 Toll-free Phone: 1-888-888-0029 Email: prov@bcss.org
Charitable Registration #11880 1141 RR0001

bcss.org | facebook.com/BCSchizophreniaSociety | twitter.com/BCSchizophrenia

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Youth Worker: ______________________________

Phone Number: ______________________ Email Address: ______________________

Other Information

Is help with transportation (bus tickets) required? ______________________

Please describe any allergies, medicial conditions or medications that facilitators should be aware of:

Who is part of the participant's support system?

What are the participant's favourite activities and interests?:

Additional information or concerns:

Form completed by:

Date:

Please return forms by fax, email, or call to arrange pick-up:
Rachel Phillips, Coordinator Kids/Teens in Control
Fax: 604-270-9861
Email: kidsincontrol@bcss.org
Phone: 778-903-2752

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