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

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