Mental Health Family Resource Centre

FAMILY SUPPORT SERVICES- BCSS- Referral Form

Please scan and email / fax to:

NW Regional Educator:
Cell: (250) 922-5178 **Fax:** (250) 635-8206
E-mail: terrace@bcss.org
Usual Office Hours: Monday to Thursday 9:00 a.m. to 4:00 p.m.

Program Goals and Objectives:

- To provide support, education, assistance, and advocacy services for families and/or close friends of individuals being diagnosed with and/or recovering from any major mental illness: such as Schizophrenia, Bipolar Disorder, Depression, and other related disorders, a diagnosis is not required.
- This service is provided under contract with the Ministry of Health. The individual with the diagnosis of mental illness can be under 19 and the family can still receive these services. All of our services are free and people can self-refer.

Family Member's Name: _____

Address: _____

Email: _____

Phone: _____

Diagnosis of ill relative: _____

What is the relationship of the ill relative to the family member?

_____

Is this a first episode? _____yes ____no

Is relative currently hospitalized? _____yes _____no Hospital name _____

Family member prefers contact via:

__ **Mail**

__ **Email**
*Would they also like to be on Family Email Distribution list? yes / no

__ **Phone -** best time to call _____ ok to leave a message? yes / no

Referred by (please print) _____ **Date** _____