Submit to: AV Hospice Society
Fax: 250-723-4471
Email: office@albernihospice.ca
Phone: 250-723-4478

Request for Services Form
Children and Youth

(Allow two business days for AVHS to process the request)

AVHS requires that referring parties gain consent from their client before making a referral. Have you gained consent from the client's guardian (if under 12) or the client (if over 12) to make this referral? If you have signed consent, please send along with referral.	If yes, initial here: ________________

Referral Information	
Date of Referral:	**Organization:**
Person Making Referral:	**Relation to Client:**
Phone Number:	**Email:**
Reason for Third Party Referral:	

Client Contact Information Please include contact information for parent/caregiver unless youth over 12 indicates they don't want parental involvement. Parents will be contacted to set up services unless specified otherwise.	
Parent Name (needed if under 12):	**Client/Youth Name:**
Address:	**DOB:**
Home Phone:	**Address:**
Cellphone:	**Cellphone:**
Email:	**Email:**

Client Background Information / Reason for Referral