REFERRAL FORM

Expanding Hope

Date(mm/dd/yy):_____

Referral Source	
Your Name	
Your Agency/Program	
Your FRN	
Your Phone Number	
Your Email Address	

Prior to completing the referral, please ensure the family has given consent and is aware that the referral is being made. Has consent been gained for this referral?

- ◯ Yes
- ◯ No

The Expanding Hope program provides service to young families (criteria defined below). If you have any questions regarding the program or criteria for referral contact Chrissy Kleinsasser (403-607-0463 or Chrissy.Kleinsasser@kindred.ca) or Andrea Christiansen (780-995-1523 or achristiansen@terracentre.ca).

Which of the Expanding Hope criteria does this family meet (check all that apply):

- ☐ A young (up to age 21) pregnant or parenting mother and/or father with infant children (0-6)
- ☐ The young (up to age 21) person's parent(s)/caregiver(s) who are grandparents or significant carers to the infants (0-6)

Client Information		
	Parent/Caregiver One	Parent/Caregiver Two (if applicable)
Name		
Date of Birth		
Phone number		
Email Address		
City/Town		
Does this client consent to text/voicemails on the number provided?	◯ Yes ◯ No	◯ Yes ◯ No
What is the best way to contact the client?		

REFERRAL FORM

Expanding Hope

Expanding Hope services are delivered virtually. Are there any challenges that may affect virtual service (ex. lack of privacy, access to technology/internet)? Please describe below:

Pregnancy Information (if applicable)	
Due Date	

Child Information (if applicable)			
	Child One	Child Two	Child Three
Date of Birth			
Are they living in the parent/caregiver's home?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Please give a clear description/reason for referral and supports needed:

Please forward referral to both Chrissy Kleinsasser at chrissy.kleinsasser@kindred.ca and Andrea Christiansen at achristiansen@terracentre.ca