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Kingston, ON
K7K 3E1
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**Rebound- A Program For Youth
Referral Form**

Date of Referral: _____

Name: _____ D.O.B.: _____ Age: _____

Address: _____

Postal Code: _____ Phone#: _____

Parent/Guardian: _____ Emergency#: _____

School: _____

Referral By: Parents School Probation Court Police Self Other

Reason for Referral- Identifiable Needs:

Is the youth aware of the referral to Rebound? ____yes ____no

How does the youth feel about the referral? (Apprehensive, interested, excited)

Are there any other agencies involved with the youth? If so, please list

How is the participant going to get to and from the Rebound Program?

Does the youth suffer from any allergies or other health issues to be aware about?

Signature of referring agency

Organization

Phone Number

Date

All referrals are confidential when received.

Referrals should be submitted to Victoria Cadue. If you have any questions please
do not hesitate to call
613-548-4535 ext.228