



# REFERRAL Family Support Network of WNC

Date of referral \_\_\_\_\_

### Referring Person

Name \_\_\_\_\_

Program/Dept \_\_\_\_\_ Contact information \_\_\_\_\_

### Please ask or assist parent/caregiver to complete the following:

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ County \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Best time to call \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work # \_\_\_\_\_

Email address \_\_\_\_\_  
\_\_\_\_\_ Confirm whether or not they would like to be added to the electronic quarterly newsletter

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Diagnosis \_\_\_\_\_

**Parent/caregiver please read and sign:** Family Support Network of WNC is a parent-to-parent program serving families of children with special needs. It is a program of Mission Children's Hospital and is affiliated with Family Support Network of North Carolina, Chapel Hill. FSN-WNC can match you with another parent of a child similar to yours. Having a parent match gives you emotional support and also helps you learn about resources in the community and other ways to help your child. FSN-WNC can also give you information about your child's disabilities and answer questions about services and school or add you to the mailing list for our quarterly newsletter only.

**I ask that Family Support Network of WNC be provided with the above information, including diagnosis. I give permission to contact me about participating in the program. This information will not be shared with other businesses or agencies without my consent unless required by law and I may withdraw from participation at any time.**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I am not ready to talk to another parent right now, but I give Family Support Network permission to:**

**PLEASE CHECK ALL THAT APPLY**

- 1)  Call me in 4 to 6 weeks to see if I am ready,
- 2)  Place my name on the mailing list for the quarterly newsletter
- 3)  Send me info about the program (or other resources - please specify \_\_\_\_\_)

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The above information was reviewed verbally with the parent and verbal consent was given until a written signature could be obtained:**

Referring Party's Signature: \_\_\_\_\_

Please submit to:

**Family Support Network of WNC - 11 Vanderbilt Park Drive - Asheville, NC 28803  
Phone 213-0033, Fax 213-0040 or by interdepartmental mail at FSN - Mission Reuter Children's Outpatient Center**