Sandi Taylor Counselling & Consulting
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Referral Form

Date of Referral *(YYYY-MM-DD)*

Type of Referral *(Select all that apply)*

- [ ] Individual
- [ ] Child
- [ ] Adolescent
- [ ] Adult
- [ ] Family
- [ ] Reunification
- [ ] Other

Intake

Contact

First Name

Middle Name

Last Name

Preferred Name

Date of Birth *(YYYY-MM-DD)*

Sex *(Select only one)*

Sex (*Select only one*)

- [ ] Male
- [ ] Female
- [ ] Intersex
- [ ] X

Gender Identity

Pronoun(s)

Email

Home Phone

Work Phone

Mobile Phone

Other Phone

Address

Street Address

City

ZIP/Postal Code

Emergency Contact

Name

Phone

Email

Street Address

City

ZIP/Postal Code

Other

Insurance

Referral

Parent/Legal Guardian(s) Information

1. Parent's Name

Street Address (if different)

City

Region

Postal Code

Phone

Email

2. Parent's Name

Street Address (if different)

City

Region

Postal Code

Phone

Email

Child Lives With *(Select only one)*

- [ ] Parent 1
- [ ] Parent 2
- [ ] Both Parents
- [ ] Other

Is CFS involved with the family? *(Select only one)*

- [ ] Yes
- [ ] No

Legal Status (ie PW, TO, VSG, VPA, Apprehension)

Agency Information

Agency requesting Service:

Street Address

City

Region

Postal Code

Current Case Manager

Case Manager's Phone

Email address

Current Supervisor

Supervisor's Phone

Email address

Foster Parent Name

Phone

Email address

Current Mental Health Concerns

Is the client experiencing any of the following*(Select all that apply)*

- [ ] Anxiety
- [ ] Depression
- [ ] Racing Thoughts
- [ ] Paranoia
- [ ] Behavioural Challenges
- [ ] Eating Disorder
- [ ] PTSD
- [ ] Addiction
- [ ] Trouble Concentrating
- [ ] Unstable Relationships
- [ ] Trauma
- [ ] Sudden Emotional Changes
- [ ] Other

If Other Selected above please specify

Is the client experiencing suicidal thoughts *(Select only one)*

- [ ] Yes
- [ ] No
- [ ] Unsure

Is the client engaging in self harm *(Select only one)*

- [ ] Yes
- [ ] No
- [ ] Unknown

Has the client made previous suicide attempt(s) *(Select only one)*

- [ ] Yes
- [ ] No
- [ ] Unsure

If you answered yes above, how many times and when was the last attempt

Aggressive Behaviour Towards *(Select all that apply)*

- [ ] Self
- [ ] Others
- [ ] Property

Substance Use History

Is there an issue with substance use *(Select only one)*

- [ ] Yes
- [ ] No
- [ ] Suspected

Type *(Select all that apply)*

- [ ] Alcohol
- [ ] Cocaine/Crack
- [ ] Heroin
- [ ] Crystal Methamphetamine
- [ ] Marijuana
- [ ] Solvents/Gasoline
- [ ] Ecstasy
- [ ] Fentanyl
- [ ] Misuse of other Prescription Drugs
- [ ] Illicit Methadone
- [ ] Misuse of over-the Counter Medication
- [ ] Other

Justice Involvement

Does the client have any legal involvement *(Select only one)*

- [ ] Yes
- [ ] No

If yes, please describe

Treatment History

Current Medications

Therapeutic strategies used in the past (ie. Play Therapy, Cognitive-Behavioural Therapy, Supportive Counselling, etc). Please specify.

Psychiatric Diagnosis *(Select all that apply)*

- [ ] No previous psychiatric diagnosis
- [ ] Current or previous psychiatric diagnosis (explain below)
- [ ] Suspected diagnosis (explain below)

Explanation of psychiatric diagnosis

Relevant developmental history *(Select all that apply)*

- [ ] Autism
- [ ] ADHD/ADD
- [ ] FASD
- [ ] Other

Intellectual delay/Cognitive impairment *(Select only one)*

- [ ] Yes
- [ ] No
- [ ] Unsure

Brain/Head Injury *(Select only one)*

- [ ] Yes
- [ ] No
- [ ] Unsure

Previous psychological assessment *(Select only one)*

- [ ] Yes
- [ ] No

Living Situation

Please tell us the client's living situation *(Select only one)*

- [ ] Stable
- [ ] Unstable
- [ ] Alone/Independent Living
- [ ] With family/partner
- [ ] Foster home
- [ ] Assisted living
- [ ] Group home
- [ ] Shelter
- [ ] Other

Financial Situation

(Select all that apply)

- [ ] Employed
- [ ] Unemployed
- [ ] Student
- [ ] Disability
- [ ] Employment and Income Assistance
- [ ] Self-Employed
- [ ] Other

Special Considerations

Other Important Information (family history of mental health issues, family issues, other stressors)

Briefly Describe the Reasons for Referral (what led to the request ie. Traumatic event, major incident, long standing issue)

Funding Source

(Select all that apply)

- [ ] Jordan's Principle
- [ ] Non-Insured Health Benefits
- [ ] Agency Contract
- [ ] Private Pay

- [ ] Insurance
- [ ] Other

Terms of Contract

1. The contract will begin upon approval of both the client (or Agency) and Sandi Taylor and will be valid for 6 months.

2. Therapeutic counselling sessions will be conducted as required to a total of 25 hours. In the case of JP and NIHB a total of 22 sessions may be approved over the course of a year. In the case of insurance, practitioner will work within the parameters of the insuring company.

- As a travelling therapist, sessions will occur in the clients home, at the school, or other location as mutually negotiated.
- One detailed report will be produced at the conclusion of the contract.
- Case consultations as requested by the case manager. This can include but not be limited to the case manager, school, other professionals.

3. Cost and Payment:

- Sessions are Invoiced at a rate of $150/session. A flat travel rate of $30/session may be added for clients residing outside Winnipeg.
- Invoices will be submitted monthly and are subject to immediate payment unless otherwise agreed upon.
- Reports are invoiced at the rate of $150/report. (Please note JP and NIHB do not pay for reports so alternative invoicing arrangements must be agreed to).
- Consultations are invoiced at a rate of $150/session for phone, video or in person local meetings and $180/session for in person, out of Winnipeg. Again JP and NIHB do not fund consultation appointments.

4. Consecutive no show or late cancelled appointments will be invoiced the following:

- The first session will be invoiced at the regular rate of $150 or $180.
- The second will be invoiced half the regular rate of $150 or $180.
- After the second consecutive no show, the contract will be placed on hold until the case manager has the opportunity to speak with their client to explain the importance of attendance and an agreement to participate has been reached.

5. Guidelines for Reporting of Child Maltreatment or Suspected Child Maltreatment:

- As per provincial protocols outlined in the Child and Family Services Ace, and
- In the event of occurrence or suspected occurrence of addition risk factors outlined (ie. Child’s suicidal behaviour, involvement with abusive partner, resumption of alcohol or other substance abuse, non-compliance with medication, or other mental health issues, etc)

6. Termination Clause:

- Either party can cancel/terminate with 30 days notice.

- [ ] By signing, I agree to retain the services of Sandi Taylor for the purpose of therapy for the above mentioned client

- [ ] Supervisor’s Signature (if required)