B.E.A.D.S.

CLIENT REFERRAL FORM

Thank you for your referral to a B.E.A.D.S. program!

REFERRING ORGANIZATION DETAILS			
Name:			
Position:			
Organization:			
Email:		**Phone:**	

CLIENT DETAILS				
Name:				
Date of Birth:				
Phone Number:				
Address:	**Street:**			
	City/Town:			
	Province:		**Postal Code:**	
Email Address:				
Gender:				
Reason for Referral:				

….Continued on next page.

info@beadswindsor.ca
www.beadswindsor.ca

B.E.A.D.S.

Type of Support Required: (Check all that apply)	Mental Health Support	☐
	Independent Living Skill Development	☐
	Developmental Disability Intervention	☐
	Behaviour/Anger Management	☐
	Social Skill Development	☐
	Employment Skill Development	☐
	____	
ADDITIONALLY:	Short Term (3-6 months)	☐
	Long Term (9 months – 1 year +)	☐
Preferred Delivery Method:	In-Person	☐
	Virtual	☐
Additional Notes:		

All referrals will be contacted by either phone or email within one (1) week of receiving the referral.

Step 1: Free Consultation and Assessment Intake Meeting – 45 minutes to 1 hour in duration.

Next: Client and B.E.A.D.S. team to determine plan of progression, goals, etc.

For all further inquiries and additional information:
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