Good Life Therapy

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REFERRAL FORM

Application Date: _____ Client/Participant name :_____

Therapy { } Consultation { } Bio- Psychosocial assessment { } Indigenous Spiritual Healing
Youth { } Child{ } Adult { } Couple { } Family { }
Area: Winnipeg { } Interlake/Eastern { } Northern Community { } Western { }

Referral Source:

Social Worker Name: _____ *Email and phone* _____

Supervisor Name: _____ *Email* _____ *Phone:* _____

CLDS Worker : _____ Email: _____ Ph: _____

Program referral: _____ Email:_____ Ph:_____

Self Referral: _____ ***Email:*** _____ ***Ph:*** _____

Date of Birth (**required**): _____ Treaty number (**required**):_____

Legal Status (if involved with CFS): _____

Care provider/foster parent name(s): _____

Address(**required**):

_____

Phone Number: _____ Email:_____

Intellectual :

Primary Disability:_____*(eg. FASD, ADHD)*

Secondary Disability:_____.

Mental Health: (eg. Emotional, Anxiety, depression, anger, Trauma, stress)

Physical:

Medications:

Family doctor:

Marital Status:

Justice Involvement:

Drug and or Alcohol use (yes or no)
Source of Income:_____

Select Other Program(s) involvement (If applicable):

- ☐ Child and Family Services : Name & number_____
- ☐ Manitoba Corrections: Name & number_____
- ☐ Probation: Name & number _____
- ☐ Employment and Income Assistance: Name & number_____
- ☐ Public Trustee's Office: Name & number_____
- ☐ Community Mental Health Program:_____
- ☐ Community Living Disability Services: Name & number_____

Emergency Person: Name & number _____

Attached social History: yes or no _____

Spiritual:

Circle of Support (family, friends, community):

_____

_____

*Band*_____

*Language spoken:*_____

*Cultural involvement:*_____

_____

*Cultural Needs:*_____

*Signature of Therapist*_____

*Signature of Client/Participant*_____

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