REFERRAL FORM

REASON FOR REFERRAL	Stage #1 | Shift- Staffed Community Home			
	Stage #2 | 24 Hour Apartment Model		Stage #3 | Community Based Living Model	

PERSONAL INFORMATION

Name: _____ Gender: F ☐ M ☐ Other ☐ Date of Birth _____

Hight _____ Weight_____ Hair color _____ Eye Color_____

Distinguishing marks _____

Cultural Background and language spoken_____

Current Address _____ Phone Number_____

Social Insurance Number _____

MB Health number (6-digit) _____ (9-digit) _____

Treaty/Band number _____

SOCIAL WORKER

SW Name_____ Agency _____

Address and Postal Code _____Phone Number _____

Fax Number _____ Email _____

Supervisor Name _____ Phone Number _____

Address _____ Email _____

LEGAL STATUS

Criminal Record? ☐ No ☐ Yes, as an adult ☐ Yes, as a youth

Is individual subject to a promise to appear, understanding parole or probation order, peace bond, or any other legal constriction for which he/she is answerable to the justice system? If yes, please describe:

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REFERRAL FORM

SAFETY AND MENTAL HEALTH INFORMATION

History of suicidal ideations? ☐ Yes ☐ No

History of self-injurious behaviours? ☐ Yes ☐ No

History of false allegations or accusations towards family, support staff, peers, or others? ☐ Yes ☐ No

Any concers with the following: ☐ Uses cannabis ☐ Uses alcohol ☐ Uses street drugs ☐ Has abused presciption drugs

Addictions? ☐ Yes ☐ No If yes, please describe:

Behavioural Concerns? ☐ Yes ☐ No If yes, please discribe:

Hospitalization? ☐ Yes ☐ No If yes, what was the reason?

Allergies: Reactions:

SUPPORT NEEDS AND ASSESSMENTS

Has a Red Ladder Assessment been completed? ☐ Yes ☐ No Are supporting documents attached? ☐ Yes ☐ No

History of gang involvement? ☐ Yes ☐ No If yes, which gang and to what extent? _____

History of AWOL? ☐ Yes ☐ No

Are there any physically aggressive behaviours? ☐ Yes ☐ No

Vulnerable to exploitation on the streets: ____

Is the individual currently banned from anywhere? _____

History of sexually inappropriate behaviours ☐ Yes ☐ No

Last review date of social history file: _____ Is the document attached? ☐ Yes ☐ No

Any involvement from: ☐ Behavioural specialist ☐ Psychiatrist ☐ Speech Therapy Psychologist ☐ Other

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HEALTH AND MEDICAL INFORMATION

Diagnoses *(Physical, Cognitive, Mental Health):* _____

Any medical concerns or chronic/recurring illnesses? _____

Medications	Reason

Does the individual require support with medications? ☐ Yes ☐ No If yes, please describe:

FAMILY CONTACT INFORMATION

Name: _____ Relationship: _____

Mailing address _____ Phone Number: _____

Name: _____ Relationship: _____

Mailing address _____ Phone Number: _____

Any contact restrictions? _____

_____

EDUCATION AND VOCATION

Current school: _____ Address _____

Phone Number _____ Age he/she will complete school: _____

If not in school, what was the last school attended: _____

Graduated from grade 12: ☐ Yes ☐ No How many years in school: _____

Enrolled in a day program? ☐ Yes ☐ No If yes, which one? _____

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ADDITIONAL INFORMATION

Is there any additional information that the agency should be aware of, including any risk management, that has not been addressed in the referral? Please include this information below.

Completed by: _____ Position/Title: _____
Print Name

Signed: _____ Date: _____

ONCE COMPLETED, PLEASE FAX THIS FORM TO OUR HEAD OFFICE.

ATTENTION: DOLLY TURNER, CEO

FAX #: **204-415-5579**