

REQUEST FOR SERVICE FOR ADULTS (18 AND OLDER)

Date of Request: _____

Personal Information (individual being referred)					
First Name:	Last Name:	Middle Name:	Date of Birth: (mm/dd/yyyy)		
Maiden Name:		Other Last Name Used:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (including mailing address):				Marital Status:	
City:	County: S <input type="checkbox"/> D <input type="checkbox"/> G <input type="checkbox"/>	Postal Code:	Home Telephone #:	Other Telephone # (Specify):	
Diagnosis:					
*	<u>IMPORTANT:</u> TWO DOCUMENTS REQUIRED AS PROOF OF RESIDENCY BEFORE REFERRAL CAN BE PROCESSED (TWO MOST RECENT UTILITY BILLS, ETC.).				*

Referring Agent (individual making the referral)	
Agent's Name:	Agency or Relationship:
Full Address:	Telephone:

Reason for Referral (What seems to be the problem/Purpose of referral)
Why are you referring this person to our Centre? What is the nature of the problem, specifically?
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CENTRE'S PROGRAMS	SERVICES BEING REQUESTED
Clinical Services	<input type="checkbox"/> Psychological Assessment <input type="checkbox"/> Consultation <input type="checkbox"/> Counselling
Family Relief Program for Developmentally Challenged Children and Adults	<input type="checkbox"/> Centre's Respite Home
Family Home Program (18+)	<input type="checkbox"/> Placement Option
Independent Respite Services	<input type="checkbox"/> In-Home Respite Funding

IMPORTANT

In order to process your referral in a timely manner, this referral form must be completed and returned within two months; otherwise, it will be assumed that our services are no longer required. Include documentation that will assist us such as past psychological or psycho-educational assessments, psychiatric assessments, report cards/transcript, individual educational plan(s), individual placement and review committee report(s), medical records, and all pertinent information regarding developmental needs of the person being referred.

Next of Kin (Parent/Guardian, etc.)			
Name:		Specify relation to individual: _____	
Address (including mailing address): Same as Individual Being Referred <input type="checkbox"/>		<input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian	
City:	Postal Code:	Home Number:	Work Number:
Name:		Specify relation to individual: _____	
Address (including mailing address): Same as Individual Being Referred <input type="checkbox"/>		<input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian	
City:	Postal Code:	Home Number:	Work Number:

Sibling History (if applicable)			
NAME OF SIBLING(S)			
DATE OF BIRTH			
PROBLEM/ACHIEVEMENT			

Language			
In which language do you prefer receiving your services in? <input type="checkbox"/> English <input type="checkbox"/> French			
What language is spoken in the home? <input type="checkbox"/> English only <input type="checkbox"/> French only <input type="checkbox"/> Both <input type="checkbox"/> Other _____			
Individual Referred	Mother Tongue (English) <input type="checkbox"/> (French) <input type="checkbox"/> _____ (Other) <input type="checkbox"/>	Individual Referred	Second Language (English) <input type="checkbox"/> (French) <input type="checkbox"/> _____ (Other) <input type="checkbox"/>
<input type="checkbox"/> Mother	Mother Tongue (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>	<input type="checkbox"/> Mother	Second Language (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>
<input type="checkbox"/> Father	Mother Tongue (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>	<input type="checkbox"/> Father	Second Language (English) <input type="checkbox"/> (French) <input type="checkbox"/> (Other) <input type="checkbox"/>
Correspondence and Documentation Preference: <input type="checkbox"/> English <input type="checkbox"/> French			

***** VERY IMPORTANT *******School History — complete names and locations of all schools attended**

Name of Present School:	Current Grade Level:	Type of Program: <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/>
Name of Previous School:	Grades attended: From _____ To _____	Type of Program: <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/>
Name of Previous School:	Grades attended: From _____ To _____	Type of Program: <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/>
Name of Previous School:	Grades attended: From _____ To _____	Type of Program: <input type="checkbox"/> 50/50 <input type="checkbox"/> Immersion <input type="checkbox"/> Core <input type="checkbox"/> Living & Learning <input type="checkbox"/> Co-op <input type="checkbox"/> Resource Assistance <input type="checkbox"/> Special Education <input type="checkbox"/>
Identification Placement & Review Committee Completed (IPRC): <input type="checkbox"/> No <input type="checkbox"/> Yes		Individual Education Plan Completed (IEP): <input type="checkbox"/> No <input type="checkbox"/> Yes
Did the individual being referred repeat any grades? (if applicable)		

Employment History (Adult Being Referred)

Currently Employed: <input type="checkbox"/> No <input type="checkbox"/> Yes	If not employed, indicate income source:	
If yes, where? _____ _____	→ Ontario Disability Support Program (pension disability) Developmental delays <input type="checkbox"/> Physical <input type="checkbox"/> Psychiatric <input type="checkbox"/>	
Position: _____ _____	→ Unemployment Insurance Commission (benefits) <input type="checkbox"/>	
Start Date: _____	→ Ontario Works <input type="checkbox"/> Workfare <input type="checkbox"/> Contact Person: _____ Ontario Works	
	→ Worker's Compensation <input type="checkbox"/>	
Name of Last Employer:		
Position:	Duration:	Reason:

Does the individual being referred have a driver's license? No Yes **If yes, how long?** _____

Is the individual being referred currently involved with any other services and/or currently waiting to receive any other services?

PRESENTLY RECEIVING			WAITING LIST	
<i>Organization</i>	<i>Name</i>	<i>Service</i>	<i>Organization</i>	<i>Service</i>

Has the individual being referred received any types of service in the past? Speech Physiotherapy
OT Psychiatric Psychological Individual Therapy Correctional Family Counselling

Pertinent Documentation to Obtain in Determining Eligibility for our Services:

Formal Assessment (psychological, psycho-educational, psychiatric) No Yes

If yes, Name of Agency: _____ Date: _____

Others (medical reports) No Yes

If yes, Name: _____ Date: _____

Language	
Can the individual understand what is being said to him/her?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can the individual express himself/herself clearly?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can the individual print or write in full sentences?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can the individual read newspapers, magazines and books?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Daily Living Skills	
Does this person live on his/her own?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can this individual perform household chores? (full course meals, cleaning)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can this individual manage his/her own money without assistance? (bank account, pay bills)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can the individual purchase his/her own things?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can the individual get around in the community? (go to a movie, a restaurant by himself/herself)	<input type="checkbox"/> No <input type="checkbox"/> Yes

Socialization	
Can the individual tell time?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can this individual keep appointments?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can this individual manage his/her own feelings?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does this individual have a group of friends?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does this individual have a best friend?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does this individual have a girlfriend/boyfriend?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Does the individual being referred have any children? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes,			
NAME OF CHILD(REN)	1)	2)	3)
DATE OF BIRTH			
PROBLEM/ACHIEVEMENT			
CHILD'S MOTHER			
CHILD'S FATHER			

Physical Problems	
Hearing Checked <input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Checked <input type="checkbox"/> No <input type="checkbox"/> Yes
Outcome	Outcome

Medical Professionals (Family Doctor, Pediatrician, Specialist, Psychiatrist, etc.)	
Name: Specialty: Address: Telephone Number:	Name: Specialty: Address: Telephone:

MEDICATIONS (if applicable)		
<i>Name of Medication</i>	<i>Dosage</i>	<i>Reason</i>
Who prescribes the medication?		

Consent Section	
Do you consent to services?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you giving us permission to inform the referring agent (when applicable) about the status of the referral?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Signature of Individual being Referred: _____ Date: _____	

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