NEW DIRECTIONS
FOR CHILDREN, YOUTH, ADULTS & FAMILIES

ALTERNATIVE SOLUTIONS
DAY SERVICE REFERRAL FORM

PLEASE ENSURE THAT **ALL** INFORMATION IS DOCUMENTED

PLEASE RETURN TO:

Pete Kennedy
Program Manager
400-717 Portage Avenue
Winnipeg, Manitoba, R3G 0M8
Phone: 204-786-7051 Fax: 204.774.6468

DEMOGRAPHIC INFORMATION: ☐ **NEW** ☐ **RE-REFERRAL**

DATE OF REFERRAL: _____

PARTICIPANT INFORMATION

NAME: **SEX:** ☐ **Female** ☐ **Male**

(Surname) **(Given Names)** **Referral For:**

ADDRESS: ☐ TERAGY ☐ D.R.E A.M.
☐ TRANSITION ☐ S.A.I.D.
☐ MILESTONES ☐ KRIYA

POSTAL CODE:
PHONE#:

D.O.B._____
Day/month/year

MHSC#_____ **PHIN#**_____

SIN#_____ **SOCIAL ALLOWANCE #**_____

LEGAL DECISION MAKING STATUS:

A. ☐**SELF**

B. ☐ **PUBLIC TRUSTEE - NAME:** _____

☐**FINANCIAL** ☐ **PERSONAL**

C. ☐ **FAMILY GUARDIANSHIP: NAME:** _____ **PHONE #** _____

LEVEL OF CARE_____ **LIVING SITUATION**_____

MEDICAL INFORMATION

Diagnosis (Physical/Cognitive)_____

_____

Associated Disabilities:
MENTAL HEALTH_____

MOTOR (Ambulatory/Non Ambulatory)
_____

SENSORY (Hearing, vision)	**COMMUNICATION (Non Verbal, ASL)**

Seizure Disorder: Yes_____ No_____ Type:_____

Comments:

PRESCRIPTION MEDICATION			
NAME	**DOSAGE**	**TIME TAKEN**	**PURPOSE**

GENERAL BEHAVIOUR

☐ **Passive**	☐ **Anxious**	☐ **Physically Acts-Out**	☐ **Repetitious Behaviour**
☐ **Assertive**	☐ **Overactive**	☐ **Self Injurious**	☐ **Defiant**
☐ **Impulsive**	☐ **"Street Wise"**	☐ **Verbally Acts-Out**	☐ **Introverted**
☐ **Cooperative**	☐ **Underactive**	☐ **Demanding**	☐ **Friendly**
☐ **Outgoing**	☐ **Motivated**	☐ **Obsessive**	☐ **Sensory Issues**
☐ **Sociable**	☐ **Emotional/Sensitive**	☐ **Challenges Authority**	☐ **Enjoys Leadership Roles**

Is there an Individual Behaviour or Risk Plan for the Participant? ☐ **Yes** ☐ **No**

Is there an Approved Restraint Plan for the Participant? ☐ **Yes** ☐ **No**

Describe any problem behaviours, potential triggers, and appropriate Staff responses:

Please list some of the Participant's preferred activities:

SELF-HELP SKILLS

□ **Independent** □ **Verbal Reminders Required** □ **Some Physical Assistance Required** □ **Full Assistance Required**	**Explain:**

FAMILY ORIGINS/CULTURAL BACKGROUND

LANGUAGES **Primary Language**	**Other Languages**	

ABORIGINAL STATUS

TREATY NUMBER	**BAND NUMBER**

PROGRAM HISTORY
(Day Service, workshops, schools, competitive employment, work experience)

Placement	Start Date	Finish Date	Reason Leaving	Placement Description

SERVICE REQUEST

□ **Work Experience**
□ **Basic Living Skills**
□ **GED**
□ **Recreation Leisure**
□ **Community Awareness**
□ **Sensory Processing**
□ **Social Skills**
□ **Basic Literacy**
□ **Anger Management**

REFERRAL SOURCE

REFERRING AGENCY_____

CONTACT PERSON (I.E. Teacher/CSW)_____
Office: _____

ADDRESS_____ **POSTAL CODE:**_____

PHONE_____ **FAX:** _____

CONTACT/CARE PROVIDER_____ PHONE_____