NEW DIRECTIONS

FOR CHILDREN, YOUTH, ADULTS, AND FAMILIES

ADULT DAY SERVICE REFERRAL FORM

PLEASE ENSURE THAT **ALL** INFORMATION IS DOCUMENTED

PLEASE RETURN TO:

Pete Kennedy
Program Manager
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:
(Surname) (Given Names)

SEX: ☐ Female ☐ Male ☐ Transgender

Referral For:

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

ADDRESS:

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**

Has the Individual had an SIS assessment done? ☐ **Yes** ☐ **No**

- **If yes, what level did they score? (1 – 2 – 3 – 4 – 5 – 6 - 7)**

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**	☐ **Recreation Leisure**	☐ **Social Skills**
☐ **Basic Living Skills**	☐ **Community Awareness**	☐ **Basic Literacy**
☐ **GED**	☐ **Sensory Processing**	☐ **Anger Management**

REFERRAL SOURCE

REFERRING AGENCY_____

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

ADDRESS_____ **POSTAL CODE:**_____

PHONE_____ **FAX:** _____

CONTACT/CARE PROVIDER_____ **PHONE**_____