

**Home Services**

**REFERRAL FORM**

**Referral for Services in:**

**Adult Home Share Shift Staffed Homes**

**Community Homes for Children Child Home Supports**

**Adult Family Supports Deaf Home Supports**

**Referrals can be sent to:**

**Attention: Melanie Anonuevo Fax: 204-774-6468**

**Phone: 204-786-7051 ext. 5375**

**Email:** [Melanie.Anonuevo@newdirections.mb.ca](mailto:Melanie.Anonuevo@newdirections.mb.ca)

**Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| **Demographic Information** | |
| Name: | |
| Address: | |
| Postal Code: | Phone: |
| Date of Birth: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_  day month year | Gender: Male Female  Transgender \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Legal Status: | |
| MHSC # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHIN # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SAHS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TREATY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BAND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIN # **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Adult Specific Information:** | |
| EIA Worker Name and Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CSW Name and Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has funding been confirmed: Yes/No SIS Level (1 to 7): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Child Specific Information:** | |
| Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Level (Circle one): 4 5  Will this child be eligible for CLdS funding after age 18: Yes/No Unsure – assessment not completed | |
| **Type of Service Required:** | |
| Home Share Foster Home  24 Hour Shift Staffed Home - Adult 24 Hour Shift-Staffed Home - Child  Supported Independent Living Family Supports  Requires 24 hour Supervision: Yes/No | |
| **Current Living Situation** (i.e. another agency, home with parents, roommates, number of staff during day/night): | |
|  | |
| **Reason for Move:** | |
|  | |
| **Family Involvement** | |
| Name of Main Family Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Legal Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Support and Social Network:** Include in this section people in this person’s life that help this person make informed decisions, supports the person to feel a sense of community and belonging, and offers emotional support outside of a service relationship. Also include people in this person’s life that they enjoy spending time with or who have known this person for a long time (i.e. relatives, friends, significant other, community members, community organizations, community memberships, cultural involvement, other agency involvement). | |
| **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Community Participation and Membership:** Please list community activities and group memberships that this person regularly engages in. Share interests and hobbies. | |
| **What support is required for this person to increase community participation and membership (i.e. exploring interests, increased experience, support etc.)?** | |
| **Connection to Culture:** Share information regarding this person’s connection to their culture, spirituality, community, language, traditions etc. What may they need to increase the connection if this is their goal? | |
|  | |
| **Communication** (i.e. ASL, verbal, language spoken, non-verbal, strategies, communication devices) | |
|  | |
| **Diagnoses** | |
| |  |  |  | | --- | --- | --- | | **Description** | **Date Given** | **Professional** | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   **Reports**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Included in Referral: Yes/No Please forward all relevant reports including (but not limited to): Psychological Assessments, Occupational Therapy/Physiotherapy Reports, Psychiatric Assessments, Individual Education Plans, Social History, Supports Intensity Scale.** | |
| **Medical Concerns/Needs** (i.e. medication, seizures, issues with mobility/motor skills, allergies, dietary needs, sensory needs/sensitivities etc.) | |
|  | |
| **Sleep Routine** | |
|  | |
| **Safety and Well- Being:** Please describe areas where this person will need support to keep themselves and others safe, or strategies to manage risk associated with choice or health (i.e. eating, finances, shopping, street safety, sexual health, exploitation, aggression etc.) | |
|  | |
| **Social History** | |
| |  |  | | --- | --- | | Physical Abuse | Sexual Abuse | | Physical Aggression | Suicidal Attempts | | AWOL | Substance Abuse | | Physical Disabilities | Involvement with the Law | | Self-Injurious/Self-harming Behavior | Other (Cruelty to Animals, Fire Setting etc.): |  |  | | --- | | Please comment on any of the above noted items that were checked off: | | |
| **Day Program/School** | |
| Individual currently attends: (check applicable)  Day Program  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Day Service   * + Does the individual want to attend a day program/work opportunity?  YES  NO   + Comment on what the individual does during the day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If No Current School name of last school attended \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last grade completed \_\_\_\_\_\_\_\_\_\_\_\_\_ When was this person last in school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is transportation currently provided to and from day program/school?  YES  NO  If yes, who is the transportation provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If yes, will this mode of transportation continue post move?  Yes  No  Unsure | |
| **Reason for Referral** | |
|  | |
| **Please Describe the Ideal Residential Environment for this Individual** | |
| **Living with a Single Male**  **Living with a Single Female**  **Couple (no kids)**  **Family with kids**  **Group home setting**  **Supported Independent Living**  **At home with family**  **Wants to live with another participant**  **Wants to/ needs to be the only participant**  **Wants to live with animals**  **Does not want to live with animals**  **Geographic Preference \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Smoker**  **Other:** | |
| **Is There Any Other Information You Want to Share that Would Assist Us In Our Initial Understanding of the Types Of Supports this Individual Requires or Would Desire?** | |
|  | |
| **Referral Source** | |
| Referring Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Consent to Receive Services and Exchange of Information**

The following individual has been referred to Home Services with New Directions:

Name:

Date of Birth:

By signing below, there is an agreement for:

* The above individual to receive requested services from New Directions
* Specific Home Services Area to exchange information or consult with significant others and/or other service providers **when relevant** to support the individual (please circle all that may be applicable)

|  |
| --- |
| * **Significant others** (e.g. parents, legal guardian, partner, children, etc.) * **Direct service providers** (e.g. Foster parents, School, Daycare, Doctor, other New Directions’ services) |
| * **Funder** (e.g. Children’s DisAbility Services, Community Living Disability Services, Child and Family Services, Employment Income Assistance, insurance company) |
| * **Psychology/Behavioural** (e.g. Psychology, Behavioural, Non-violent Crisis Intervention Consultation, Trauma Informed, Addictions, Gender & Diversity) |
| * **Health Services** (e.g. Occupational Therapy, Physiotherapy, Psychiatric Nursing, Psychiatry, Pharmacy, Massage, Speech & Language Pathologist) |
|  |
| **Other** (e.g. Action Therapist, Justice, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Information released or gathered will be handled according to governmental standards of privacy protection.

This Consent will expire one (1) year from the date signed unless otherwise specified below.

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| --- | --- |
| **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Please circle appropriate category: Self, Parent, Guardian, and Substitute Decision Maker) | **Witness**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Date signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of Expiry**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (if not one year) |