Life's Journey Inc.

Miikana Pimatiziwin

REFERRAL PACKAGE

Residential ☐ **Outreach** ☐ **Day Program** ☐ **Spectrum Connections** ☐
Rural Connections ☐ **Addictions** ☐ **Clinical Services** ☐ **Elder/Cultural Services** ☐
Home Share ☐ **Cluster Housing** ☐
Adult ☐ **Youth** ☐

Name of Individual:	**Gender:**
(Surname) **(Given Names)**	
Alias/AKA:	**Height:**
SIN #:	**Weight:**
Health #:	**Identifying Marks:**
PHIN #:	
Current Living Situation (check applicable category)	
Foster ☐ **Group Home** ☐	
Emergency placement ☐ **Homeless** ☐	
Room/apartment ☐ **Family** ☐	
Address:	
(City) **(Postal Code)**	
Phone #	**Hair Color:**
Age: **Date of Birth:** **(YYYY/MM/DD)**	**Eye Color:**
Place of Birth:	
Languages spoken:	
Band Name (if applicable) **Treaty #**	**Email Address:**
SDM: **contact:**	

Reason for referral

_____

_____

_____

Summary of Current Situation

_____

_____

_____

SUPPORT NETWORK

Name	Organization	Phone	Address

Individuals Social Network (e.g. Extended family & those important to youth/adult)

Name	Relationship	Phone	Address

Family Involvement

Name	Relationship	Phone	Address

Skills and Strengths
Areas of interest:
Area that the person excels at:
Skills (both achieved and person wishes to develop):

Describe Individuals Cultural Practices & Preferences:

_____

_____

_____

Is there an elder involved with the individual? **Yes ☐ No ☐**

Name: _____ **Phone #:** _____

MEDICAL AND MENTAL HEALTH
Medical Diagnoses:
(Diabetes, STI's, etc.)
Medical Personnel involved:
Name: **Phone:**
Name: **Phone:**
Allergies:
Diagnoses: (Please attach assessment)
Cognitive Disability Yes ☐ No ☐
Neurological Disability Yes ☐ No ☐
Mental Health Diagnoses:
Physical limitations: **Other:**
Confirmed Prenatal Alcohol Exposure: Yes ☐ No ☐
Neurobehaviours consistent with ethanol exposure in utero:
Yes ☐ No ☐ Unknown ☐
History of Hospitalization (mandatory). Please list dates and hospitals:

Assessments Completed (please attach):

Psychological assessment Yes ☐ No ☐ Date: _____**By:** _____
Psychiatric assessment Yes ☐ No ☐ Date: _____**By:** _____
Occupational therapy assessment Yes ☐ No ☐ Date: _____**By:** _____
Speech & language assessment Yes ☐ No ☐ Date: _____**By:** _____
Other: _____ **Date:**_____**By:** _____
Other: _____ **Date:** _____ **By:** _____
Eligible for Community Mental Health: Yes ☐ No ☐ pending
Eligible for Community Living disABILITY Services: Yes ☐ No ☐ pending
Eligible for Provincial Special Needs: Yes ☐ No ☐ pending
Government service worker (ie CSW): contact:

CFS Involvement:	**Yes ☐**	**No ☐**	**N/A ☐**
CFS Agency:			
CFS Worker:		**Phone #:**	
CFS Authority:			
Permanent ward:	**Yes ☐**	**No ☐**	
Extension of care:	**Yes ☐**	**No ☐**	
From:	**To:**		
(YYYY/MM/DD)	**(YYYY/MM/DD)**		
Voluntary Placement Agreement:	**Yes ☐**	**No ☐**	
From:	**To:**		
(YYYY/MM/DD)	**(YYYY/MM/DD)**		
Temporary Order:	**Yes ☐**	**No ☐**	
Other:			

School Currently Attending: _____
Last School Attended: _____
Educational Level/type of program: _____
Guidance Counselor: _____
Resource Teacher: _____ **Phone#:** _____

Vocational

Source of Income: _____
Monthly Income amount: _____
Employment and Income Assistance Worker: _____
Phone #: _____ **FAX #:** _____
SASH #/Social Allowance #: _____
Day Program Currently Attending: _____
Coordinator : _____ **Phone#:** _____

Work History:

_____
_____
_____

Does the person have children **Yes ☐** **No ☐**
Is the youth or adult pregnant? **Yes ☐** **No ☐**
Does the person currently parent children? **Yes ☐** **No ☐**
What is the age(s) of the child(ren)? _____

HISTORY				
Legal Involvement:				
Criminal Record:	**Yes ☐**	**No ☐**		
History of Criminal Charges:				
Current Charges/No contact orders:				
Name of Lawyer:			**Phone #:**	
Probation:	**Yes ☐**	**No ☐**	**Expires:**	**(YYYY/MM/DD)**
Probation Worker:			**Phone #:**	
Recognizance Order:	**Yes ☐**	**No ☐**	**Expires:**	**(YYYY/MM/DD)**
Gang Affiliation:	**Yes ☐**	**No ☐**		
Gang:				
Instituational History:				

Please Describe the Individual:

Do you consider high risk to self harm? Yes ☐ No ☐

Does the individual require supports to minimize the risk of self harm?
Yes ☐ No ☐

Does the individual have any history of self harm or ideation Yes ☐ No ☐

_____

Does the individual have behavior that indicates a fascination with fire or been involved in fire starting incidents? Yes ☐ No ☐

Does the individual require supports to minimize risk to cause physical violence?
Yes ☐ No ☐

Does the individual require supports to minimize risk of victimization? Yes ❑ No ❑

Does the individual require supports to minimize the risk of repeating sexually offending behavior? **Yes ☐ No ☐**

Has substance abuse caused any problems for the person: Yes ☐ No ☐
Explain:

_____
_____
_____
_____
_____
_____

REFERRAL SOURCE

Name of organization/agency: (if applicable) _____
Worker: _____ **Address:** _____
Phone # _____ **Fax #:** _____
Relationship to youth/adult _____ **Date of Referral:** _____
Email Address:_____
Reason for Referral:

_____
_____
_____
_____
_____

THE FOLLOWING INFORMATION MUST BE ENCLOSED WITH YOUR REFERRAL PACKAGE: Psychological Assessment(s), Psychiatric Assessment(s), Social History, FASD Assessment, Criminal Records, Probation Order, & any other relevant documentation.

FAX THIS FORM TO THE FOLLOWING:

Life's Journey Inc.
Fax #: 204-772-1784