Referral and Application Form

* ***In order for this application to be processed; please complete this form in full and attach pertinent consents, assessments and reports.***

Referral Date: _____

Please identify which program(s) you wish to refer this individual to. See our website at www.ofii.ca for programming information.

☐	Residential Treatment Centers
☐	Specialized Home Share Program
☐	Independent Living Support Program
☐	Individual / Group Therapy / Risk and Need Assessment
☐	Adaptive Skills Day Program and Drop-in Center

Participant Information:

Name:	**Gender:**
Age:	**DOB:**
SIS Score:	**Phone:**
Address:	**City/Town:**
Province:	**Postal Code:**
MHSC No:	**PHIN No:**
Treaty/Band No:	**EIA No:**

Does the client have an intellectual disability? ☐ Yes ☐ No
Please state intellectual functioning level and attach their most recent psychological assessment.

Does the client have a physical disability? ☐ Yes ☐ No If so, please describe:

If the client is transitioning to Adult Services, have they been approved? ☐ Yes ☐ No
Assigned Adult Worker's Name:

Address:

City/Town:

Postal Code:

Phone:

Transition Date:

Referring Agency Information:

Referring Worker:	**Phone:**
Referring Agency:	**Fax:**
Address:	**E-mail:**
City/Town:	
Province:	**Postal Code:**

Client's Legal Guardian:	**Phone:**
Address:	**E-mail:**
City/Town:	
Province:	**Postal Code:**
Client's Legal Councel:	**Phone:**
Address:	**E-mail:**
City/Town:	
Province:	**Postal Code:**

Agencies Currently Involved:

Worker / Contact	Agency	Address / Phone

Past Agency Involvement and Placement History: Please list date and contact person for all residential and community placements. Continue on back if necessary. ***(Please attach relevant Residential and Community placement reports.)***

Worker / Contact	Agency	Date	Address / Phone

Family Involvement: Please list details below.

Name	Relationships	Frequency of Contact	Address / Phone

Medical History: List any recurring and / or ongoing medical concerns.

Please list any current medication and the prescribing Physician.

Medical Doctor:	**Phone:**
Address:	**Fax:**
City/Town:	**E-mail:**
Province:	**Postal Code:**

Psychiatric History: Please list any recurring and /or ongoing psychiatric conditions. ***(Please attach a current evaluation from the client's Psychiatrist.)***

Please list any current medication and the prescribing Psychiatrist.

Psychiatrist:	**Phone:**
Address:	**Fax:**
City/Town:	**E-mail:**
Province:	**Postal Code:**

Educational History: ***(Please attach pertinent educational reports, along with latest literacy and learning skills assessment if available.)***

Estimated Literacy & basic math skills:	
Last school attened:	**Grade Level:**
Educational Contact:	**Phone:**
Address:	**Fax:**
City/Town:	**E-mail:**
Province:	**Postal Code:**

Vocational / Day Program History: Please attach pertinent vocational reports.

Is the client currently employed or enrolled in a day program? ☐ Yes ☐ No If Yes:

Employer / Program:	
Contact:	**Phone:**
Address:	**Fax:**
City/Town:	**E-mail:**
Province:	**Postal Code:**

Please list significant vocational / employment placements, experiences, or skills:

Recreational/ Leisure: Please list significant recreational interests or activities

Legal History: Please attach pre-sentence reports, dispositions and pertinent orders.
Please list any past charges, please include the legal disposition and the date.

Please list any pending charges and the hearing date.

Active Cultural or Religious Practices

Presenting Behavior: Please briefly describe past and current behavioral concerns.

Current Support / Supervision Model: Please briefly describe current support and supervsion provided to the individual.

Treatment History:
Has the client received any form of therapy for problematic behaviors? ☐ Yes ☐ No If Yes:

Problematic Behavior	Form of Therapy (Group/Individual/Other)	Therapist / Program

If known, what was the response to therapy?

Authorization

By submitting this form you agree with the following statements:

I confirm that the information contained in this document is true and includes all relevant information required to correctly assess this referral.

Referral agencies only:

I confirm that I have the applicant's authorization to submit this application on their behalf and that the information contained in this document is true and includes all relevant information required to correctly assess this referral.

Data Consent:

I understand that the information on this form which I am submitting will be processed and stored by OFII within a secure environment and will be used for the purposes of contact, risk assessment and background checks.

If you agree with OFII processing and storing your details; please check 'YES' below.

Data Consent *

☐ YES - I give consent to OFII to process and store my information.

Please enclose a completed **client consent form for transmission of information** and all pertinent reports and assessments, and forward to :

Brad Torgerson
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