Name of Person Being Referred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Postal Code

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred language: Other: Interpreter required?

Primary Contact (if Not the Person Being Referred): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Postal Code

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substitute Decision Maker Name (if necessary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Postal Code

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do they consent for? Financial Health

Has a Capacity Assessment been completed?Choose an item.

**LIVING SITUATION AT TIME OF REFERRAL**

|  |  |  |
| --- | --- | --- |
| Independent | Group Home | Hospital |
| With Family | Shelter | Homeless |
| Supported Housing | Correctional Facility | Safe Bed |
| Other: | | |

**REFERRAL SOURCE**

|  |  |  |
| --- | --- | --- |
| Community Agency | Court Diversion | Court System |
| Jail | Family/Friend | Hospital |
| Probation & Parole | Network Partner | Police Referral |
| Short Term Crisis Support Bed | School | Self |
| Other: | | |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Postal Code

**REASON FOR REFERRAL**

|  |  |
| --- | --- |
| Court support | Behavioural Issues (Safety Concerns) |
| Need counsel/legal aid |  |
| Mental Health/ Dual Diagnosis |  |

**Next Court Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lawyer/Duty Counsel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Current Criminal Charges** | **Date Charged** | **Current Status** |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Past Criminal Charges** | **Date Charged** | **Current Status** |
|  |  |  |
|  |  |  |
|  |  |  |

Verbal Consent Received Date:

Has eligibility for Developmental Services been confirmed? Yes No

*Signature of Person Completing Date*

**Please forward the complete referral package RSA Admin:**

**Fax: 519-421-4249**

**or**

**Email:** [**rsaadmin@woodstockhospital.ca**](mailto:rsaadmin@woodstockhospital.ca)