CSBD
Community Services
OF BELLEVILLE
AND DISTRICT

REFERRAL

Adult Protective Services

Referral Date: _____

Name: _____ **Pronoun:** _____

D.O.B.: _____ **Age:** _____

Address: _____ _____ _____
Street City Postal Code

Contact: _____ _____ _____
Home Cell Email

Referral Source Information

Name: _____ **Agency:** _____

Email: _____ **Phone:** _____

Referral Reason:
Check only those that apply and provide specific details

- ☐ Accessing services _____
- ☐ Housing _____
- ☐ Long-term planning _____
- ☐ Service co-ordination _____
- ☐ Funding application _____
- ☐ Legal issues _____
- ☐ Other _____

Diagnosis

Describe the individual's developmental disability and/or diagnosis:
(i.e.: IQ 70 or less; functioning at or below the 2nd percentile, etc.)

Recent Assessments:

Assessment	Assessor	Date

12 Moira Street East, Belleville, ON K8P 2R9
Tel: 613-966-7413 ● Fax: 613-966-2357 ● Toll Free: 1-800-966-7413
Email: csbd@csbd.on.ca ● website: www.csbd.on.ca

Funding

Case Manager: _____ **Phone:** _____

ODSP: $ _____ **Passport:** $ _____ **Other:** _____ $ _____

Information

Current living arrangements:

Educational and Vocational history:

Significant others:

Other Agencies or Supports:

Name/Title	Agency	Phone

Other Information:
(i.e.: medication, family information, funding such as ACSD, SSAH)

Documentation included with referral:

- ☐ Consent to Share Information – for all agencies listed above
- ☐ _____
- ☐ _____
- ☐ _____

Declaration & Consent

By signing below, I confirm I have read and reviewed this referral, and agree with its submission.

Person Referred	Date
Referring Person Signature	Date