

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.)

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Recent Assessments:

Assessment	Assessor	Date

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