



Moving Forward Referral Form

Referral Source: _____ Date: _____

Agency/Organization: _____ Contact #: _____

Applicant Information

Surname: _____ First Name: _____

Contact# _____

Date of Birth: _____

Eligible under a Youth Service Agreement until age: _____ 18 _____ 21

S.I.N. _____ M.C.P. _____

Emergency Contact Name/Contact # _____

Check all that apply:

- The applicant has agreed to be referred to Moving Forward
- The applicant is identified as having complex mental health needs
- The applicant has exhausted support service options
- The applicant is willing to work toward living independently in the community
- The applicant is exhibiting risk behaviors which are either escalating or not being reduced
- The applicant is in an unstable living situation

Moving Forward Referral Form

***Upon intake, we will request to meet with referrer to attain further details. Incomplete forms will be returned. Please be specific and detailed as possible as spaces are limited. All responses should be printed clearly and returned by fax.**

Support/Relationship Information:

Please include information for ALL significant people who are/have been involved in the applicants life

PARENTS

Name	Contact (address/telephone)	Frequency of contact with the applicant
1.		
2.		

For each of the persons named above, please describe in detail the existing strengths and areas of concern with the relationship(s).

1.

2.

PROFESSIONALS WHO ARE/HAVE BEEN ASSOCIATED WITH APPLICANT
Example; psychiatrist, psychologist, mental health worker, youth worker, residential treatment worker, caregiver, probation officer, teacher, employer, other

Name	Professional role/agency	Contact (address/telephone)	Frequency of contact	Will professional continue to be involved (yes/no)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Is the applicant currently in the process of being referred to a professional? If yes, what initiated the referral?

Medical/Mental Health Information:

Please include ALL information relating to the applicant's physical and mental health. Be specific and as detailed as possible.

Does the applicant have a current family doctor? YES NO
If yes, provide name and telephone number:

Does the applicant have any physical health concerns? YES NO
If yes, identify treatment and impact on young person.

Has the applicant been hospitalized in the past? YES NO
If yes, provide details of history:

Financial Information:

Please include ALL available income, assistance, and financial support details.

Under the Youth Service Agreement what is the monthly living allowance for the applicant?

\$ _____

Will full amount be transferred to Moving Forward? YES NO
If no, who will be responsible for distributing monthly living income?

Please provide a detailed breakdown of monthly allowance i.e. rent, transportation, clothing, groceries etc.

Living Expense	\$ Amount

Is the applicant receiving additional income from other sources? YES NO
If yes, provide details:

If applicable, is funding available for additional travel i.e. home visits? YES NO
If yes, provide travel details:

Housing Information:

Please include ALL relevant information regarding current living situation and housing history

Is the applicant in need of housing if accepted to Moving Forward? YES NO
If yes, please describe special considerations if seeking housing?

Are there other housing/accommodation applications pending? YES NO
If yes, please list:

HOUSING HISTORY

Begin with most recent residence

Residence (address/telephone)	Begin Date	End Date	Reason for Leaving	*Type

** Type refers to group home, family, apartment, foster care, independent living arrangement, bed-sitter, treatment facility, prison etc.*

Support Information:

Please include ALL relevant information regarding service provision for the applicant.

Moving Forward offers support during days/evenings. Is the applicant capable of independent living under these support provision hours? YES NO

If any, provide in detail the level of support required by the applicant:

What level of support does the applicant require in the areas listed below:

	Independent	Minimal Support	Moderate Support	Intensive Support
Self-care				
Transportation				
Budgeting				
Housekeeping/Cooking				
Interpersonal Relationships				

Please indicate when the applicant required intense supervision (one-on-one, 24 hour etc.)

Agency name	Type of Service	Staff ratio	Hours utilized for supervision per day	Hours allocated for supervision per day	Reason for ending supervision

Risk Behavior:

Please include ALL relevant information regarding current or past risk behaviors.

Has the applicant been verbally/physically aggressive in the past? YES NO

Is the applicant currently aggressive? YES NO

If yes to the above, provide details (i.e. anger, violence):

Does the applicant have a history of substance use? YES NO

Is the applicant currently involved with substances use YES NO

Is/has there been involvement in treatment service YES NO

If yes to the above, provide further detail (i.e. substance type, duration, frequency)

Has the applicant engaged in self-mutilation? YES NO

Is the applicant currently self-mutilating? YES NO

If yes to the above, provide details (i.e. frequency, severity):

Has the applicant attempted suicide in the past? YES NO

Is the applicant currently suicidal or having suicidal thoughts? YES NO

If yes to the above, provide details (i.e. frequency, hospitalization):

Has the applicant been involved with sexual exploitation? YES NO

Is the applicant currently involved in sexual exploitation? YES NO

If yes to the above, provide details:

Has the applicant been involved with the justice system? YES NO

Has the applicant been incarcerated? YES NO

Is the applicant on probation? YES NO

Does the applicant have current charges? YES NO

If yes to the above, provide further detail (i.e. probation office, terms of probation, reason for incarceration/charge etc.):

What is your assessment of the strengths and positive traits of the applicant.

Are there any other concerns/issues that have not been identified that the Moving Forward staff should be aware of.

List professionals that you feel would like to be included with Moving Forward service plan

SIGNATURE OF REFERRER: _____ **DATE:** _____

SUPERVISOR/MANAGER: _____ **DATE:** _____