Turning Leaf (Inc.) Referral Form	Assessment	☐	Residential	☐
	Respite	☐	Day Service	☐
	Community Support	☐	Transitional/Stabilization	☐
	Family Counseling	☐	Guided Living	☐

(Please check applicable boxes)

Participant Information

Name:_____ Sex:_____D.O.B: _____

Address:_____

Home Phone_____Work Phone_____Cell:_____

Occupation:_____Employer: _____

Marital Status_____Name of Spouse/Partner _____

Emergency Contact: _____

Immediate family:_____Languages: _____

PHIN #	SIN #
Treaty/Band #	

Referring Agency Information:

	Address	**Phone/Email**
CSW:		
Care provider:		
Mental health worker:		
EIA:		
SDM:		
Other:		

Agencies Currently Involved:

Agency	**Worker / Contact**	**Address / Phone**	**Services provided**

Medical Information

Diagnoses (physical/cognitive/mental health):		
Physician(s):		
Psychiatrist:		
Medications	Dose	Purpose
Does the participant require any assistance with his/her medications? Yes ☐ No ☐		
Physical challenges: Yes ☐ No ☐	If yes, please indicate:	
Addictions: Yes ☐ No ☐	If yes, please indicate:	
Hospitalizations: Yes ☐ No ☐	Cause for Treatment:	

Educational/Vocational involvements

Currently enrolled in school?	Yes ☐ No ☐	School:	Contact:
Enrolled in a day program?	Yes ☐ No ☐	Agency:	Contact:
Employed? Yes ☐ No ☐	F/T ☐ P/T ☐	Employer:	

Conflict with the law

Currently in Custody?		
Type of offenses		

Reason for referral: Please identify presenting issue (e.g., symptomatic behavior, participant needs, etc.) and/or goals for service.

Please identify at-risk behaviors (e.g., behavior that places the participant or others at risk)

Please attach all relevant psychological, educational, law conflict, and vocational reports to this form and forward to:

Turning Leaf Community Support Services Incorporated
2nd Floor – 2585 Portage Avenue
Winnipeg, MB R3J 0P5
Attn: Melissa Falk, Intake Coordinator

Phone: 204 221-5594 ext.219
Fax: 204 219-1821

Email: melissafalk@turningleafservices.com