REQUEST FOR SERVICES FOR ADULTS (18 AND OLDER)

Date of Request:

Personal Information (individual being referred)			
First Name:	**Last Name:**	**Middle Name:**	**Date of Birth:** (mm/dd/yyyy)
Maiden Name:	**Other Last Name(s) Used:**	**Preferred Gender Identity:**	
Address (including mailing address)**:**		**Marital Status:**	
City:	**Postal Code:**	**Home Telephone #:**	**Email/Other Telephone #** (specify)**:**
Diagnosis:			

I M P O R T A N T

Professional document(s) required confirming both **age and residency** before referral can be processed (birth certificate, baptismal certificate, passport, driver's license, Ontario health card, utility bill, stub, bank statement, rental, or lease agreement, etc.).

Referring Agent (individual making the referral)	
Agent's Name:	**Agency or Relationship:**
Full Address:	**Telephone Number:**

Reason for Referral (what seems to be the problem/purpose of referral)
Why are you referring this person to our Centre? What is the nature of the problem, specifically?

Centre's Programs	Services Being Requested
Clinical and Support Services	☐Psychological Assessment ☐Counselling ☐Behavior Consultation
Family Relief Program for Developmentally Challenged Adults	☐Centre's Respite Home
Family Home Program	☐Placement Options
Independent Respite Services	☐In-Home Respite Funding

I M P O R T A N T

To process your referral in a timely manner, this referral form must be completed and returned within 2 months; otherwise, it will be assumed that our services are no longer required. Include documentation that will assist us such as past psychological or psycho-educational assessments, psychiatric assessments, transcript, individual education plan(s), identification, placement and review committee report(s), medical records, and all pertinent information regarding developmental needs of the person being referred.

inspire
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Tel.: (613) 937-3072 or 613-932-4610 1-800-267-1724 **Fax:** (613) 937-4550 www.inspire-sdg.ca

Next of Kin (parent/guardian, etc.)			
Name:			**Specify relation to individual:**
Address (including mailing address)**:** **Same as individual being referred**☐			☐Biological ☐Step ☐Adoptive ☐Guardian
City:	**Postal Code:**	**Home Telephone #:**	**Email/Other Telephone #** (specify)**:**
Name:			**Specify relation to individual:**
Address (including mailing address)**:** **Same as individual being referred**☐			☐Biological ☐Step ☐Adoptive ☐Guardian
City:	**Postal Code:**	**Home Telephone #:**	**Email/Other Telephone #** (specify)**:**

Sibling History (if applicable)			
Name of Sibling(s)			
Date of Birth			
Problems			
Achievements			

Language			
What language do you prefer receiving your services in? ☐English ☐French			
What language is spoken in the home? ☐English only ☐French only ☐Both ☐Other_____			
☐Individual Referred	Mother Tongue (English)☐ (French)☐ (Other)☐	☐Individual Referred	Second Language (English)☐ (French)☐ (Other)☐
☐Mother	Mother Tongue (English)☐ (French)☐ (Other)☐	☐Mother	Second Language (English)☐ (French)☐ (Other)☐
☐Father	Mother Tongue (English)☐ (French)☐ (Other)☐	☐Father	Second Language (English)☐ (French)☐ (Other)☐
Correspondence and Documentation Preference: ☐English ☐French			

VERY IMPORTANT School History — complete names and locations of all schools attended		
Name of Present School:	**Current Grade Level:**	**Type of Program:** ☐50/50 ☐Immersion ☐Core ☐Living & Learning ☐Co-op ☐Resource Assistance ☐Special Education ☐
Name of Previous School:	**Grades Attended:** From To	**Type of Program:** ☐50/50 ☐Immersion ☐Core ☐Living & Learning ☐Co-op ☐Resource Assistance ☐Special Education ☐
Name of Previous School:	**Grades Attended:** From To	**Type of Program:** ☐50/50 ☐Immersion ☐Core ☐Living & Learning ☐Co-op ☐Resource Assistance ☐Special Education ☐
Name of Previous School:	**Grades Attended:** From To	**Type of Program:** ☐50/50 ☐Immersion ☐Core ☐Living & Learning ☐Co-op ☐Resource Assistance ☐Special Education ☐

Identification Placement & Review Committee **(IPRC)** Completed: ☐No ☐Yes	Individual Education Plan **(IEP)** Completed: ☐No ☐Yes

Did the individual being referred repeat any grades? (if applicable) _____

_____

Employment History (adult being referred)	
Currently Employed: ☐No ☐Yes If yes, where? _____ _____ Position: _____ _____ Start Date: _____	If not employed, indicate income source: →Ontario Disability Support Program ☐Developmental delays ☐Physical ☐Psychiatric →Unemployment Insurance Commission (benefits) ☐ →Ontario Works☐ Workfare☐ Contact Person: _____ →Worker's Compensation☐
Name of Last Employer:	

Position:	Duration:	Reason:

Does the individual being referred have a driver's license? ☐No ☐Yes **If yes, how long?** _____

Is the individual being referred currently involved with any other services and/or currently waiting to receive any other services?

PRESENTLY RECEIVING			WAITING LIST	
Organization	Name	Service	Organization	Service

Has the individual being referred received any types of services in the past? ☐Speech ☐Physio ☐OT ☐Psychiatric ☐Psychological ☐Individual Therapy ☐Correctional ☐Family Counselling

Pertinent Documentation to Obtain in Determining Eligibility for our Services:

Formal Assessment (psychological, psycho-educational, psychiatric) ☐No ☐Yes

If yes, Name of Agency:_____ Date:_____

_____

Others (Medical Reports) ☐No ☐Yes

If yes, Name:_____ Date:_____

_____

Language	
Can the individual understand what is being said to him/her?	☐No ☐Yes
Can the individual express himself/herself clearly?	☐No ☐Yes
Can the individual print or write in full sentences?	☐No ☐Yes
Can the individual read newspapers, magazines, and books?	☐No ☐Yes

Daily Living Skills	
Does this person live on his/her own?	☐No ☐Yes
Can this individual perform household chores? (full course meals, cleaning)	☐No ☐Yes
Can this individual manage his/her own money with assistance? (bank account, pay bills)	☐No ☐Yes
Can the individual purchase his/her own things?	☐No ☐Yes
Can the individual get around in the community? (go to a movie, restaurant by himself/herself)	☐No ☐Yes

Socialization	
Can the individual tell time?	☐No ☐Yes
Can this individual keep appointments?	☐No ☐Yes
Can this individual manage his/her own feelings?	☐No ☐Yes
Does this individual have a group of friends?	☐No ☐Yes
Does this individual have a best friend?	☐No ☐Yes
Does the individual have a girlfriend/boyfriend?	☐No ☐Yes

Does the individual being referred have any children? ☐No ☐Yes If yes,			
Name of Child(ren)			
Date of Birth			
Problems/Achievements			
Child's Mother			
Child's Father			

Physical Problems	
Hearing Checked ☐No ☐Yes	Vision Checked ☐No ☐Yes
Outcome	**Outcome**

Medical Professionals (family doctor, specialist, psychiatrist, etc.)	
Name: Specialty: Address: Telephone Number:	Name: Specialty: Address: Telephone Number:
Name: Specialty: Address: Telephone Number:	Name: Specialty: Address: Telephone Number:

Medications (if applicable)		
Name of Medication	Dosage	Reason
Who prescribes the medication?		

Consent Section	
Do you consent to services?	☐No ☐Yes
Are you giving us permission to inform the referring agent (when applicable) about the status of the referral?	☐No ☐Yes
Signature of Individual Being Referred:	**Date:**

Comments (please include any behavioural concerns, observations, or any other pertinent information, etc.)