## **REQUEST FOR SERVICES FOR ADULTS (18 AND OLDER)**

**Date of Request:**

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| **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.). | | | | | | | | |

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

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| **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?** |
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| **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 |



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| **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. |

775 Campbell Street, Cornwall, Ontario K6H 7B7

**Tel.:** (613) 937-3072 1-800-267-1724 **Fax:** (613) 937-4550 [www.inspire-sdg.ca](http://www.inspire-sdg.ca)

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| **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)**:** | | |

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

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| **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 | |

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| **\* \* \* V E R Y I M P O R T A N T \* \* \*** | | | |
| **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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **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?** \_\_\_\_\_\_\_\_\_\_\_

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

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| **PRESENTLY RECEIVING** | | | **WAITING LIST** | |
| Organization | Name | Service | Organization | Service |
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**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Others** (Medical Reports) 🞎No 🞎Yes

If yes, Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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 |

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| **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 |

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| **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 |

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| **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** |  |  |  |

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| **Physical Problems** | |
| Hearing Checked 🞎No 🞎Yes | Vision Checked 🞎No 🞎Yes |
| **Outcome** | **Outcome** |

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| **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: |

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

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| **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:** | |

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