Ranch Ehrlo Society Referral Form
Integrated Supportive Living (ISL) Program

Required:

- Health services card & number
- Birth certificate
- Immunization record
- Legal status document (e.g., guardianship, trusteeship)
- Social insurance number
- Funding approval (letter/email)
- Medical administration record or medication list

PERSONAL INFORMATION

Name of referring agency	**Mailing address of referral agency**	
City	**Province**	**Postal code**

Primary contact name	**Phone**	**Email**	**Preferred method of contact** ☐ Phone ☐ Email ☐ Both

Legal name (First, Last)		**Preferred name** (if applicable)			
Sex at birth ☐Male ☐Female	**Gender** (if differs from sex at birth)	**Preferred pronouns**	**Date of birth**		
			Day	Month	Year

Birthplace	**Provincial health number**	**First Nation/Band/Métis local and Status Number** (if applicable)	**NIHB number** (if applicable)

Legal status (e.g., independent, guardian, trustee)	**Is English their first language?** ☐ Yes ☐ No	**Other language(s) spoken:**
Current living situation:		

REFERRAL AGENCY/FUNDING INFORMATION

*Please note funding beyond SAID is required.

Funding approved: ☐ Yes ☐ No	**If no, please explain**:

Will support invoices be sent to the referring agency? ☐ YES ☐ NO
(If "No", please complete section below)

Name of funding agency		
Mailing address of funding agency	**City**	**Province**

Postal Code	**Email**	**Phone**

If invoices should be directed elsewhere, please indicate alternate address/email below:

Mailing address of invoice office	**City**	**Province**

Postal Code	**Email**	**Phone**

ASSESSMENT

Have any of the following assessments been completed (If yes, please include with submission)

Psychological ☐ Yes ☐ No **Adaptive behaviour** (e.g., ABAS-3) ☐ Yes ☐ No **Vocational** ☐ Yes ☐ No	**Supports Intensity Scale** (e.g., SIS-A) ☐ Yes ☐ No **Daily Living Support Assessment (DLSA)** ☐ Yes ☐ No **Functional behaviour** ☐ Yes ☐ No	**Speech/Language** ☐ Yes ☐ No **Occupational Therapy** ☐ Yes ☐ No **Other** _____

WORK/VOCATIONAL/DAY PROGRAMMING HISTORY

Current work/vocational/day programming (last placement if no current placement):	
Date last attended	**Address/location**
Describe the individual's thoughts, beliefs, and expectations towards work/vocation/day programming. What is working and what is not working with that routine?	

CULTURAL IDENTITY
Please describe the individual's cultural background or identify what is meaningful to them.
Are there any cultural activities, gatherings or ceremonies the individual is connected to, participates in, or would like to be connected to?
STRENGTHS AND INTERESTS
What are the individual's personal strengths and qualities that they take pride in?
Are there any specific hobbies, community groups or interests the individual enjoys or would like to become involved in if provided the opportunity (clubs, sports, arts, music, dance, singing, etc.)?
COMMUNITY AND SOCIAL CONNECTIONS
Are there any cultural leaders, community members, or mentors who are actively connected and support the individual?
SPIRITUAL CONNECTIONS
Is the individual involved with any religious groups or engaged in any spiritual practices? Is the individual connected to a spiritual advisor?

FAMILY/SIGNIFICANT OTHER INFORMATION	
Name of family member/significant other:	**First Nation/Métis local/band (if applicable):**
Relationship with the individual:	**Address/Last known location:**
Phone:	
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Phone:	
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Relationship with the individual:	**Address/last known location:**
Phone:	
Name of family member/ significant other:	**First Nation/Métis local/band (if applicable):**
Relationship with the individual:	**Address/last known location:**
Phone:	

Other significant connections (community, friend, elder, organization) that should remain in place or should be encouraged?	
Name	Relationship to the individual
Address/location	Phone
Name	Relationship to the individual
Address/Location	Phone

MEDICAL		
HEALTHCARE PROVIDERS		
Physician	**Name**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Dentist	**Name**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Optometrist	**Name**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Psychiatrist	**Name**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)
Other (e.g., SLP, OT, counsellor)	**Name and designation**	**Phone #/location**
	Date last seen (approximate if seen within the last 12 months)	**Date of next appointment** (if applicable)

MEDICATIONS

Name of medication	Prescribing physician	Dosage (time/frequency)	Pharmacy	Are they actively taking the medication?

MEDICAL AND DEVELOPMENTAL NEEDS

	Please provide details (severity, date of diagnosis, diagnosing Dr, how it is being treated/managed, has an assessment been completed)
Mental health disorders/ diagnoses (e.g., ASD, ADHD, ODD, FASD, Bi-Polar, RAD, etc)	☐ Yes ☐ No If yes, please describe:
Medical conditions (seizures, diabetes, asthma, cerebral palsy, etc)	☐ Yes ☐ No If yes, please describe:
Recent Hospitalizations (e.g., Psychiatric, Substance misuse, Detox, etc). Include dates and details	☐ Yes ☐ No If yes, please describe:
Does the individual have a communicable disease(s)	☐ Yes ☐ No If yes, please describe:
Allergies	☐ Yes ☐ No If yes, please describe:
Dental/optical/hearing concerns	☐ Yes ☐ No If yes, please describe:
Learning disabilities	☐ Yes ☐ No If yes, please describe:
Eating concerns (swallowing concerns, challenges with amount or rate, PICA, etc.)	☐ Yes ☐ No If yes, please describe:
Bowel/bladder concerns (continence, smearing, support required, etc.)	☐ Yes ☐ No If yes, please describe:
Sleep challenges (challenges getting or staying sleeping, wandering at night, wakes early, etc.)	☐ Yes ☐ No If yes, please describe:
Communication needs (speech delays, augmented communication, expressive or receptive language delays)	☐ Yes ☐ No If yes, please describe:
Mobility needs (mobility challenges, mobility device, altered balance, etc.)	☐ Yes ☐ No If yes, please describe:
Sensory needs (sensory tools like weighted blankets or vests, sensory defensiveness/preferences/triggers)	☐ Yes ☐ No If yes, please describe:

Daily living skills challenges (bathing, dressing, grooming, medical management, etc.)	☐ Yes ☐ No If yes, please describe:
Independent living skill challenges (budgeting, laundry, cleaning, community transport, etc.)	☐ Yes ☐ No If yes, please describe:
Immunizations Are they up to date/what was the last age they received them? Please detail. Are there any personal beliefs towards immunizations we should be made aware of?	

LEGAL

Has the individual been involved in any illegal activities? ☐ Yes ☐ No **Do they have charges?** Yes ☐ No ☐ **Are they on probation?** ☐ Yes ☐ No **Are they involved with the Review Board?** ☐ Yes ☐ No **Are they involved with the Mental Health Court?** ☐ Yes ☐ No	**If yes to any question, please provide details:**	
Please provide contact information for any other relevant workers (e.g., PO, RAMP, Legal Aid)		
Name of worker	**Title/Relationship**	**Contact Info**
Name of worker	**Title/Relationship**	**Contact Info**

Please email the completed referral form to
CLSreferrals@ranchehrlo.ca

If you have any questions about this form or how to submit a referral, please contact Monica Rivers, clinical consultant at 306-520-8543 or Jane Powell, director of clinical and community services at 306-781-1260