Ranch Ehrlo Society
Supportive Living Program Referral Form

Note: Before submitting this referral, please ensure the following documents are included.

REQUIRED DOCUMENTS

☐ Health Services Card & Number
☐ Birth Certificate
☐ Immunization Record
☐ Status Number (if applicable)
☐ Wardship Documents (Section 9, Long Term Ward, etc.)
☐ Funding Approval (letter/email)

IF APPLICABLE

☐ Education Assessment
☐ Psychological Assessment
☐ Adaptive Behavior
☐ Daily Living Support Assessment
☐ Recent Photo
☐ Genogram
☐ Court Documents, Probation Order, Undertaking
☐ Out of Home Care Child Placement Request
☐ Supports Intensity Scale
☐ Functional Behaviour
☐ Other Assessments (OT, SLP, etc.)
☐ Other:

PARTICIPANT INFORMATION

Legal Name *(First, Last)*		**Preferred Name** *(if applicable)*	
Sex at Birth ☐ M ☐ F	**Gender** *(if differs from sex at birth)*	**Preferred Pronouns**	**Date of Birth**

PHYSICAL DESCRIPTION

Height:	**Weight:**	**Eye Colour:**
Hair Colour:	**Hair Style:**	**Complexion:**
Scars:	**Tattoos:**	**Glasses (Y/N):**
Ethnicity:	**Other:**	

Birthplace	**Provincial Health Number**	**First Nation/Band/Métis Local and Status Number** *(if applicable)*	**NIHB Number** *(if applicable)*
Welfare Status *(e.g., Sec 9, apprehension, LTW, etc.)*	**Legal Status Expiry Date**	**English as First Language?** ☐ Yes ☐ No	**Other Language(s):**

Previous Referral to Our Agency:
☐ Yes ☐ No

Diagnosed Intellectual Disability:
☐ Yes ☐ No ☐ Queried

CLSD Eligible:
☐ Yes ☐ No

PARTICIPANT PLACEMENTS

Name / Location (Present → Past)	Length of Time	Comments *(reason for leaving / 1:1 staffing)*

REFERRAL AGENCY INFORMATION

Legal Name of Referring Agency		Mailing Address of Referring Agency	
City		Province	Postal Code
Primary Contact Name	Phone	Email	Preferred Method of contact ☐ Phone ☐ Email ☐ Both
Supervisor's Name	Phone	Email	Preferred Method of contact: ☐ Phone ☐ Email ☐ Both
If you will be using Sask Interprovincial Courtesy supervision, have you applied? ☐ Yes ☐ No Additional Info:			

REFERRAL AGENCY INFORMATION

Funding Approved: ☐ Yes ☐ No	If no, please explain:	
Will Care and Treatment invoices be sent to the referring agency? ☐ YES ☐ NO (If "No", please complete section below)		
Name of Funding Agency	If Jordan's Principle: ISC No. Expiry Date:	
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 (including city and province)		
Postal Code	Email	Phone

EDUCATION/VOCATION

Current School/Vocation Placement *(last placement)*:		Current Grade
Date Last Attended	Address / Location	
Is the participant currently in a specialized program? ☐Yes ☐ No If yes, please describe:		
Have any of the following assessments been completed (If yes, please include with submission)		
Psychoeducational Assessment ☐ Yes ☐ No	Occupational Therapist ☐Yes ☐No	Speech / Language ☐Yes ☐No
Describe the participant's behavior and attitude towards school/vocational program:		
Level of Support Required:		

CULTURAL IDENTITY AND PERSONAL BACKGROUND

CULTURAL IDENTITY

What is the participant's cultural background, and what cultural traditions or practices are important to them and their family? Are there any cultural events or ceremonies they take part in or hope to join?

STRENGTHS AND INTERESTS

What strengths does the participant feel proud of? Do they have hobbies, community activities, or interests (sports, clubs, arts, music)? What goals or future plans would they like to work toward?

COMMUNITY AND SOCIAL CONNECTIONS

Is the participant connected to their home community? If so, how? Are there cultural leaders, mentors, or community members who support them?

SPIRITUAL CONNECTIONS

Is the participant involved with any religious groups or engaged in any spiritual practices?

FAMILY/KINSHIP INFORMATION

Name of Primary Caregiver	**First Nation/Metis Local/Band** *(if applicable)*	
Relationship with participant and potential for reunification:	**Address / Last Known Location**	
Phone	**Phone Contact Allowed** ☐ Yes ☐ No	**Visits Allowed** ☐ Yes ☐ No
Name of Secondary Caregiver	**First Nation/Metis Local/Band** *(if applicable)*	
Relationship with participant and potential for reunification:	**Address / Last known location**	
Phone	**Phone Contact Allowed** ☐ Yes ☐ No	**Visits Allowed** ☐ Yes ☐ No

OTHER SIGNIFICANT CONNECTIONS (FAMILY, FRIENDS, ELDERS)

Name	**Relationship to Participant**
Address / Location	**Phone**

Contact Permitted: ☐ Yes ☐ No ☐Supervised ☐ Not presently, but would like to

Are any family members or important connections currently participating in a Ranch Ehrlo program such as Family Treatment, Supported Living, Youth Group Living, or Treatment Foster Care?

Are there any people who this participant should not have contact with? If yes, who and why?

LEGAL

Has the individual been involved in any illegal activities? ☐ Y ☐ N **Do they have charges?** ☐ Y ☐N **Are they on probation?** ☐ Y ☐ N **Are they involved with the Review Board?** ☐ Y ☐ N **Are they involved with the Mental Health Court?** ☐ Y ☐ N	**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**

If there are any Non-Contact Orders in place, please provide information below		
Name	**Relationship**	**Details**

MEDICAL

HEALTHCARE PROVIDERS

PHYSICIAN	**Name**	**Phone / Location**
	Date Last Seen *(approximate if within the last 12 months)*	**Next Appointment** *(if applicable)*
DENTIST	**Name**	**Phone / Location**
	Date Last Seen *(approximate if within the last 12 months)*	**Next Appointment** *(if applicable)*
OPTOMETRIST	**Name**	**Phone / Location**
	Date Last Seen *(approximate if within the last 12 months)*	**Next Appointment** *(if applicable)*
PSYCHIATRIST	**Name**	**Phone / Location**
	Date Last Seen *(approximate if seen within the last 12 months)*	**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)*	**Next Appointment** *(if applicable)*

MEDICATIONS				
Name of Medication	*Prescribing Physician*	*Dosage (Time/Frequency)*	*Pharmacy*	*Actively Taking?*

MEDICAL HISTORY	
Please Provide Details *(Include severity, diagnosis date, diagnosing physician, current treatment/mgmt., and whether an assessment has been completed.)*	
Mental Health Disorders / Diagnoses *(e.g. ADHD, ODD, FASD, Bipolar Disorder, RAD, etc.)*	
Medical Conditions *(e.g., seizures, diabetes, asthma, cerebral palsy, etc.)*	
Paranoia / Hallucinations *(Is the participant experiencing auditory or visual hallucinations?)*	
Allergies	
Dental / Optical Concerns	
Learning Disabilities	
Recent Hospitalizations (e.g., psychiatric, substance misuse, detox. Include dates and details).	
Immunizations (Are they up to date? What was the last age they received them?)	

DEVELOPMENTAL NEEDS
Daily Living Skills
What is the individual's level of independence with daily tasks (bathing, dressing, grooming, eating)?
Are adaptive aids or prompts needed (e.g., verbal cues, visual schedules)? If yes, please describe:
Safety Considerations

Are there any specific safety risks to be managed *(e.g., elopement, aggression, self-injury, sexually problematic behavior)*
What level or ratio of caregiver support is needed to ensure safety?
Positive Support Planning
Does the individual require a predictable daily schedule? If so, how is this best provided? **What strategies or supports help with transitions or unexpected changes?** **What de-escalation techniques have been effective?** *(e.g., sensory tools, quiet spaces)* **Are there specific person-centred strategies that work particularly well for the individual?**

Daily Needs and Supports	Please Provide Details
EATING ☐ Speed of eating and swallowing ☐ Recent changes in appetite ☐ Eating & swallowing challenges ☐ Food restrictions ☐ Picky eating ☐ Favourite foods ☐ Adaptations for eating *(e.g., adapted utensils, cutting food into small pieces)*	
ELIMINATION CHALLENGES ☐ Continent of bladder ☐ Continent of bowel ☐ Level of independence ☐ Supports required *(catheter, colostomy bag, medication, depends)* ☐ Feces smearing ☐ Feces digging ☐ Feces eating ☐ Sensitivities to wipes or incontinent supplies	☐ Always ☐ Sometimes ☐ Never ☐ Always ☐ Sometimes ☐ Never
SOCIAL DEVELOPMENT ☐ Understands social cues ☐ Understands and respects others' boundaries ☐ Demonstrates age-appropriate social interactions	

☐ Appropriately greet others ☐ Maintains friendships ☐ Shows interest in initiating conversations or interactions	
SENSORY	
☐ Dislikes *(e.g., loud noises, clothing tags, busy spaces)* ☐ Preferences ☐ Sensory equipment used or recommended	
MOBILITY NEEDS	
☐ Requires assistance with transferring, walking, or using mobility aids *(e.g., wheelchair)* ☐ Requires specialized equipment *(e.g., lifts, braces)* ☐ Concerns with posture, fine motor skills, gross motor skills, balance, coordination	

SLEEP

☐ Awakens at night ☐ Nightmares ☐ Wanders at night ☐ Screams or cries
☐ Refuses to go to bed ☐ Sleepwalking ☐ Leaves bedroom ☐ Not enough sleep
☐ Takes sleep aids ☐ Banging walls or items in bedroom
☐ **Typical sleep and wake times:**
☐ **Recent changes in sleep patterns:**

Uses OT-Recommended Strategies:
☐ Weighted blanket ☐ Noise machine ☐ Blackout curtain ☐ Nightlight
☐ Grow clock ☐ Sleeps with a pet ☐ Other:

COMMUNICATION

Preferred Method of Communication *(e.g., verbal, sign language, communication device, written cues)*

How well does the individual express and understand communication?

What level of assistance is needed to understand or express needs and feelings?

Communication Supports Used / Recommended

☐ Choice board ☐ PECS ☐ Social stores ☐ iPad with communication app ☐ Video modelling

Oral Motor Challenges

Can the individual follow novel instructions/requests?

☐ Yes ☐ No

Can they typically only follow routine requests?

☐ Yes ☐ No

Instruction-following ability:

☐ 1-step ☐ 2-step ☐ Multi-step

CASE PLANNING

Please summarize the primary reasons for the referral. What present circumstances led to this referral being made?

Desired Outcomes / Expectations

For the participant and/or family:

1.
2.
3.

Participant Engagement

How is the Participant involved in their case planning?

Are they aware that this referral has been made?

Family Caregiver / Involvement

Are the participant's family or caregivers supportive of this referral? ***Please explain why or why not:***

What is the anticipated period of treatment?

Discharge Plan

What is the participant's anticipated discharge plan and resource?

Submitting the Referral

Please email the completed referral form to:
intake@ranchehrlo.ca

If you have any questions about this form or the referral process, please contact our **Intake Manager** at:
(306) 552-8651