
**McMan’s PCAP First Nations REFERRAL FORM**

**Referral Source**

|  |  |
| --- | --- |
| Name |  |
| Agency |  |
| Address (including postal code) |  |
| Email |  |
| Phone number |  |

**Participant Information**

**Please complete the following.**

|  |  |
| --- | --- |
| Participant Name |  |
| Contact Number |  |
| Email |  |
| Current Address |  |
| Birth Date (DD/MM/YYYY) |  |
| Alberta Health Care Number |  |
| Band |  |
| Treaty Status Number |  |
| Total number of children |  |
| Age of youngest child |  |
| How many children reside with mom |  |
| Currently Pregnant | YES NO   |
| Currently on Birth Control | YES Method\_\_\_\_\_\_\_\_\_\_\_\_\_ NO |

**Community Services Involved**

**Please list all current agency(s) that the Participant is working with.**

|  |  |  |
| --- | --- | --- |
| **AGENCY** | **STAFF NAME** | **STAFF EMAIL & PHONE NUMBER** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Participant’s Goals for Support**

**Please comment on the participants abilities/ goals/ required level of support in the following areas.**

**Refer to the following definitions of Level of Support Needed.**

**Low or No Support required**- Managing successfully independently or need is being supported by another agency/ person.

**Medium or Light Support Required** -managing at the moment-requires support/intervention in near future.

**High or Immediate Support Required**- not able to manage at all/ now and requires immediate intervention to return to wellness.

|  |  |  |
| --- | --- | --- |
| **ASSESSMENT AREA** | **LEVEL OF SUPPORT NEEDED** | **COMMENTS** |
| **Connections to Community Resources**Including current supports and identifying resources that could benefit participant. |  |  |
| **Cultural Connection**Any consideration(s) to meet and support participant’s connection to their culture |  |  |
| **Financial Literacy**Including access and/or eligibility to reliable funding source, access to bank account, ability to work with/follow a budget, pay bills, issues with financial abuse to or from others. |  |  |
| **Independent Life Skills**Including maintaining and attending to daily hygiene, clean clothes, completing chores, cooking, access to nutritious food. |  |  |
| **Time Management Skills**Including ability to remember and keep previously scheduled appointments, ability to make appointments, ability to understand what supports to contact regarding specific concerns (ex. Call doctor’s office for physical ailment). Ability to get to and from appointments  |  |  |
| **Housing Supports**Has a safe, consistent place to stay, able to manage tenancy, pay monthly bills on time and make necessary repairs in a timely manner.  |  |  |
| **Legal Guidance & Support**Including any current or ongoing legal issues and support. |  |  |
|  **Mental Health & Wellness I**ncluding any diagnosis, medications, concerns, assessments, or treatment. |  |  |
| **Physical Health & Wellness**Including any diagnosis, medications, concerns, assessments, or treatment. |  |  |
| **Recovery Supports**Including substance use, daily amount, route of use, education around safe use. Concerns when participant is using or not using. |  |  |
| **Vocational/Educational Supports**Including identified goals, previous experiences, education level. |  |  |
| **Any Other Supports Identified**Other area(s) that could provide/increase participants wellness and well-being |  |  |

**Participant Consent**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ provide consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ staff to disclose the personal

 (Participant or Designate Name) (Agency/Staff Name)

Information of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to McMan’s First Nation PCAP for the purpose of program

 (Participant Name)

service delivery. I am aware of the benefits and risks associated with this referral. I am aware that I can revoke my consent at any time. This consent is valid from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (3 months is recommended).

Referral Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Participant or Designate Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_