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**Capital Region Mental Health & Addictions Association**

**Let’s Work Program**

65 Brunswick St, Suite G23

PHONE: 506-451-9190 / FAX: 506-443-4349

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www.letswork.ca



**REFERRAL FORM**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_

**Client Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

S.I.N #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living accommodations (please specify):

⁭ Client lives independently ⁭ Family home ⁭ in home support / care home

⁭ Client is experiencing homelessness

⁭ Other :

Highest level of education received: (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current source of income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client have a vocational goal: ⁭ yes ⁭ no ⁭ uncertain

If so, please specify:

To access *Let’s Work* services, individuals must be “*workforce* *ready*”. To be workforce ready there is an assumption that a client is able to work without permanent supports, able to dedicate a reasonable amount of time towards their job search and be willing to engage in various activities (some independently) as outlined in the individualized employment action plan created with a Career Transition Facilitator.  
  
Do you believe the client is “workforce ready”? ⁭ yes ⁭ no ⁭ uncertain

Type of work sought:

* Occasional / Casual
* Part time
* Full time

Type(s) of work recommended:

Identified Barriers:

Relevant medical and psychiatric history including duration:

Impact of illness or medication on daily function (please explain):

History of suicidal or violent behavior? ⁭ yes ⁭ no ⁭ uncertain (clarify as needed)

Physical conditions/limitations/allergies etc:

Does the Client have a Criminal Record? ⁭ yes ⁭ no ⁭ uncertain

Other Information:

**Referred by**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_