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**Capital Region Mental Health & Addictions Association**

**Let’s Work Program**

466 Queen Street, Unit #2 (Wilmot Alley)

PHONE: 506-206-0130 / FAX: 506-443-9001

tami.bovaird@crmhaa.ca

www.letswork.ca



**REFERRAL FORM**

***As of April 1, 2025, there is a waitlist for Let’s Work Employment Counselling services.***

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

**Referral Information:**

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

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

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

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

Living accommodations (please specify):

 lives independently  Family home  in home support / care home

 experiencing homelessness Other:

Highest level of education received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Does this person have an employment 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 an Employment Counsellor.*  
Do you see this person as being “workforce ready”?  yes no uncertain

Type of work sought:

 Occasional / Casual  Part time  Full time

Type(s) of work recommended:

Identified Strengths:

Identified Barriers:

Impact of mental health barriers/diagnosis/medications on daily functioning (please explain):

Relevant medical and psychiatric history including duration:

Is there any history of suicidal ideation and/or behavior?  yes  no uncertain

Is there any history of violent behavior?  yes  no  uncertain

(clarify as needed)

Are there any physical conditions/limitations/allergies, etc. to be aware of?

Does this person have a Criminal Record?  yes  no  uncertain

Other Information:

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

**Relationship to referred Person**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_