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**Capital Region Mental Health & Addictions Association**

**Let’s Work Program**

466 Queen Street

PHONE: 506-458-1803 / FAX: 506-443-9001

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Does the client 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 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 mental health barriers/diagnosis/medications on daily functioning (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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_