Linden Place

Residential Program
1270 Shamrock Bay
Box 129, Winkler, MB. R6W 4A4
Ph: (204) 325-9384 Email: mackenzie@edenhealthcare.ca

CLINICAL REFERENCE (To be completed by referring worker)

Applicant's Name: ______________________________ Date: ________________

Address: ____

____ D.O.B. ________________

Person completing reference: ____

Position: ______________________________________ Phone No.: ______________

Name of Organization: ____

Address: ______________________________________ Postal Code ____________

How long have you known the applicant? ___________________________________

How well would you say you know the applicant?

☐ Slightly ☐ Moderately Well ☐ Very Well

What is your relationship to the applicant? _________________________________

Psychiatric Diagnosis of Applicant: _______________________________________

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Could you please provide information on the applicant's hospitalization history related to the psychiatric disability:

Date	Length of time in hospital	Comments

Name of Psychiatrist: ________________________________ Ph. No.: __________________

Current Prescribed Medication(s): ____

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What is the applicant's present living situation? _____________________________________

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General comments on the applicant's experience in past living situations:

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Linden Place is designed to assist individuals develop skills that will allow them greater choices in terms of where they will live. In which of the following areas do you feel the applicant requires assistance to develop skills or connect with resources:

- Building relationships with others ☐
- Looking after personal appearance ☐
- Doing household activities ☐
- Managing money ☐
- Using services in the community ☐
- Being involved in activities ☐
- Connecting with appropriate mental health services ☐

Can you identify behaviours or other issues in the applicant's life which might interfere with the living environment at Linden Place?

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Please identify qualities and strengths which the applicant possesses which could be used to assist in developing a rehabilitation plan.

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Please describe what you see as the applicant's current support network:

Person	Relationship to Applicant	Intensity of Relationship (low, medium, high)

Financial Information: Self Supporting ☐ Family Support ☐ Social Assistance ☐

Describe: ____

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Please attach social history, recent (last 3 months) psychiatric assessment, occupational therapy assessment if available, any other information which would be of assistance in working with the applicant.

Committee Use Only:

Date referral received: ____________________ Accepted ☐ Rejected ☐

Entry Date: ________________________ Termination Date: ____________________________