

**Linden Place**

Residential Program

Box 129, Winkler, MB. R6W 4A4

Ph: (204) 325-9384 Email: housing@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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

<u>Date</u>	<u>Length of time in hospital</u>	<u>Comments</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Psychiatrist: \_\_\_\_\_ Ph. No.: \_\_\_\_\_

Current Prescribed Medication(s): \_\_\_\_\_

---

---

What is the applicant's present living situation? \_\_\_\_\_

---

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

---

---

---

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?

---

---

---

---

---

---

---

---

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

---

---

---

---

---

---

---

---

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

<u>Person</u>	<u>Relationship to Applicant</u>	<u>Intensity of Relationship</u> (low, medium, high)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Financial Information: Self Supporting  Family Support  Social Assistance

Describe: \_\_\_\_\_

---

---

**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 <input type="checkbox"/> Rejected <input type="checkbox"/>
Entry Date: _____ Termination Date: _____