Linden Place

Residential Program

Email:housing@edenhealthcare.ca or Fax: 204.480.7114

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:

Date	Length of time in hospital	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____

~~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:

Person	Relationship to Applicant	Intensity of Relationship (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 ☐ Rejected ☐

Entry Date: _____ Termination Date: _____