Canadian Mental Health Association
Kelowna
Mental health for all

THE BRIDGE Youth & Family Services

Connected By 25 Referral Form

Office Use Only
Received: ____________

FAX COMPLETED FORM TO 250-763-4827
ATTENTION: YOUTH TRANSITIONS NAVIGATOR

THIS FORM IS TO BE COMPLETED BY THE PROFESSIONAL CURRENTLY WORKING WITH THE APPLICANT.

Connected By 25 is a collaborative project between CMHA Kelowna and the Bridge Youth and Family Services focused on meeting the needs of 16-24 year olds who are vulnerable in their transition to adulthood. Designed to assist young people at risk of falling through the cracks, Connected By 25 aims to empower youth by facilitating access to the social, emotional and material supports they need.

Referral Information			
DATE OF REFERRAL			
NAME OF REFERRING AGENT		TITLE / POSITION	
AGENCY / ORGANIZATION			
TELEPHONE		FAX	
EMAIL			
HOW LONG HAVE YOU BEEN WORKING WITH APPLICANT?			

Applicant Information					
NAME OF APPLICANT (FIRST, MI, LAST)					
ADDRESS				❑ MALE ❑ FEMALE ❑ TRANSGENDER	
MAIN PHONE/CELL				ALTERNATE CONTACT #	
DATE OF BIRTH	DD	MM	YYYY	AGE	
ETHNICITY	❑ CAUCASIAN ❑ FIRST NATIONS ❑ MÉTIS ❑ INUIT ❑ OTHER (PLEASE SPECIFY):				
S.I.N.				P.H.N.	
IS THE APPLICANT PREGNANT OR PARENTING?	❑ YES ❑ NO				

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REFERRAL DETAILS

PLEASE SELECT THE SCENARIO THAT BEST DESCRIBES THE APPLICANT'S CURRENT CIRCUMSTANCE:

- ❑ **Under** 19 years of age and requires support, resource connection and services beyond their 19th birthday
- ❑ **Over** 19 years of age and requires ongoing support, resource connection and services to assist with their transition to adulthood

WHAT ARE THE MAIN REASONS FOR SEEKING SERVICES FROM CONNECTED BY 25? *(SELECT ALL THAT APPLY)*

- ❑ INTENSIVE COMMUNITY-BASED SUPPORT
- ❑ LIFE SKILLS DEVELOPMENT / EDUCATION
- ❑ CONNECTION TO SERVICES / BRIDGING BETWEEN YOUTH AND ADULT SERVICE DELIVERY SYSTEMS
- ❑ HOUSING SUPPORT
- ❑ EDUCATION AND EMPLOYMENT SUPPORT
- ❑ SOCIAL CONNECTION / NATURAL SUPPORT NETWORK DEVELOPMENT
- ❑ ADDRESSING HEALTH / MENTAL HEALTH/SUBSTANCE USE ISSUES
- ❑ ACCESS TO INCOME SUPPORTS (INCOME ASSISTANCE, PWD ETC.)

PLEASE EXPLAIN, IN DETAIL, THE REASON FOR THIS REFERRAL:

INCOME, EDUCATION AND EMPLOYMENT HISTORY

SOURCE OF INCOME	❑ EMPLOYMENT ❑ YOUTH AGREEMENTS ❑ EMPLOYMENT INSURANCE (EI) ❑ INCOME ASSISTANCE (INCLUDES UNDERAGE IA)	❑ INCOME ASSISTANCE (PWD) ❑ INCOME ASSISTANCE (PPMB) ❑ IN CARE OF MCFD ❑ FAMILY SUPPORT ❑ OTHER (PLEASE DESCRIBE):	
CURRENTLY IN SCHOOL?	❑ YES, FULL TIME ❑ YES, PART TIME ❑ NO	LAST GRADE COMPLETED	
IF YES, NAME OF SCHOOL		IF NO	❑ WANTS TO RETURN ❑ DOES NOT WANT TO RETURN
LIST ANY TRAINING OR CERTIFICATES			
HAS APPLICANT HAD AN:	❑ EDUCATIONAL AND/OR ❑ VOCATIONAL ASSESSMENT		
DATE(S) OF ASSESSMENT		ORGANIZATION	
IS APPLICANT CURRENTLY WORKING?	❑ YES IF YES: ❑ 4-20 HRS/WK ❑ 21-3O HRS/WK ❑ 30-40 HRS/WK ❑ NO IF NO, IS APPLICANT INTERESTED IN FINDING EMPLOYMENT? ❑ YES ❑ NO		
NAME OF WORKPLACE AND POSITION			
IS APPLICANT CURRENTLY WORKING WITH OTHER SUPPORTS/SERVICES REGARDING EMPLOYMENT?	❑ YES ❑ NO IF YES, PLEASE PROVIDE DETAILS:		

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HEALTH PROFILE		
DOES APPLICANT HAVE A HISTORY OF PHYSICAL HEALTH CONCERNS?	❑ YES ❑ NO ❑ SUSPECTED/POSSIBLE ❑ DON'T KNOW	
DOES APPLICANT HAVE A PHYSICAL DISABILITY?	❑ YES ❑ NO	IF YES, PLEASE PROVIDE DETAILS:
PRIMARY HEALTH CARE	ACUTE HEALTH CARE ISSUES: ❑ YES ❑ NO CHRONIC HEALTH CARE ISSUES: ❑ YES ❑ NO IF YES TO EITHER OR BOTH, PLEASE DESCRIBE:	
DOES APPLICANT HAVE A FAMILY DOCTOR?	❑ YES ❑ NO	IF YES, PLEASE PROVIDE NAME AND TELEPHONE NUMBER:

MENTAL HEALTH AND SUBSTANCE USE PROFILE		
DOES APPLICANT HAVE ANY MENTAL HEALTH ISSUES?	❑ YES ❑ NO ❑ SUSPECTED/POSSIBLE ❑ DON'T KNOW	
STATED DIAGNOSIS (SELECT ALL THAT APPLY)	❑ ANXIETY ❑ MOOD DISORDER ❑ SCHIZOPHRENIA ❑ DEPRESSION ❑ ADHD ❑ OTHER (PLEASE SPECIFY): ____ ❑ CONDUCT DISORDER / ODD	
HAS APPLICANT BEEN DIAGNOSED WITH:	❑ FASD ❑ LEARNING DISABILITY ❑ DEVELOPMENTAL DELAY DETAILS: ____	
DOES APPLICANT HAVE A PSYCHIATRIST?	❑ YES ❑ NO	IF YES, PLEASE PROVIDE NAME AND CONTACT INFORMATION:
DOES APPLICANT HAVE A MENTAL HEALTH CLINICIAN?	❑ YES ❑ NO	IF YES, PLEASE PROVIDE NAME AND CONTACT INFORMATION:
DOES APPLICANT HAVE ISSUES RELATED TO THE USE OF SUBSTANCES?	❑ YES, CURRENT ❑ YES, HISTORICAL ❑ SUSPECTED/POSSIBLE ❑ NO	
SUBSTANCES USED (WHERE APPLICABLE)	❑ MARIJUANA ❑ COCAINE ❑ HEROIN ❑ PRESCRIPTION MEDICATION ❑ ALCOHOL ❑ CRYSTAL METH ❑ OTHER ____	
IS APPLICANT CURRENTLY RECEIVING ALCOHOL AND DRUG COUNSELLING TREATMENT SERVICES?	❑ YES ❑ NO	IF YES, PLEASE PROVIDE NAME AND CONTACT INFORMATION:

PLEASE PROVIDE ANY OTHER RELEVANT HEALTH INFORMATION:

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CRIMINAL HISTORY	
IS APPLICANT ON PROBATION?	❑ YES ❑ NO IF YES, PLEASE LIST CHARGES AND CONDITIONS AS WELL AS NAME AND CONTACT INFORMATION OF PROBATION OFFICER:
DOES APPLICANT HAVE OUTSTANDING CHARGES?	❑ YES ❑ NO IF YES, PLEASE PROVIDE DETAILS:
DOES APPLICANT HAVE A COURT DATE?	❑ YES ❑ NO IF YES, PLEASE PROVIDE DATE(S):
DOES APPLICANT HAVE A LAWYER?	❑ YES ❑ NO IF YES, PLEASE PROVIDE NAME AND CONTACT INFORMATION:

HOUSING AND SUPPORTS	
CURRENT HOUSING SITUATION	❑ APARTMENT / SUITE ❑ ROOM / ROOM AND BOARD ❑ FOSTER HOME ❑ LIVING WITH FAMILY ❑ HOMELESS (ABSOLUTE) ❑ TRANSITIONAL HOUSING ❑ SHELTER ❑ COUCH SURFING / FRIENDS (RELATIVE HOMELESS) ❑ SOCIAL / SUPPORTED HOUSING ❑ RECOVERY / TREATMENT
HOW LONG HAS APPLICANT LIVED IN CURRENT LOCATION?	
IS APPLICANT EXPERIENCING ANY BARRIERS IN FINDING OR MAINTAINING HOUSING?	❑ YES ❑ NO
HOUSING BARRIERS (WHERE APPLICABLE)	*PLEASE SELECT ALL THAT APPLY:* ❑ BEHAVIOUR NOT CONDUCIVE TO LIVING WITH OTHERS ❑ HYGIENE ISSUES ❑ NO REFERENCES ❑ ACTIVE IN ADDICTIONS ❑ LACK OF DAMAGE DEPOSIT ❑ PETS ❑ MISSING ID ❑ LIMITED KNOWLEDGE / SKILLS IN FINDING AND MAINTAINING HOUSING ❑ OTHER ______________________
PLEASE DESCRIBE THESE BARRIERS IN MORE DETAIL:	

HOUSING AND SUPPORTS (CONT'D)	
IS APPLICANT IN CONTACT WITH FAMILY?	❑ YES ❑ NO
IF YES, PLEASE DESCRIBE THE NATURE OF CONTACT AND THE RELATIONSHIP:	
DOES APPLICANT HAVE OTHER INDIVIDUALS TO TURN TO FOR SUPPORT AND ASSISTANCE?	❑ YES ❑ NO
IF YES, PLEASE IDENTIFY THESE INDIVIDUALS AND PROVIDE MORE INFORMATION:	
ARE THERE OTHER PROFESSIONAL SUPPORTS INVOLVED WITH APPLICANT, CURRENT OR HISTORICAL?	❑ YES ❑ NO
IF YES, PLEASE PROVIDE NAMES, ROLES AND CONTACT INFORMATION:	
PLEASE USE THIS SPACE TO PROVIDE ANY OTHER RELEVANT INFORMATION REGARDING APPLICANT'S NEED FOR SERVICES:	

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________________, (print name of applicant), D.O.B., ____ ____ ____ (d/m/y), hereby permit any exchange of information deemed appropriate between the Connected by 25 project and the referring agent/agency to facilitate my application. I understand that the information exchanged will be handled in a discreet and confidential manner.

APPLICANT SIGNATURE ______________________________ **DATE** ____________
(OR PERSON AUTHORIZED TO SIGN FOR APPLICANT)

APPLICANT NAME ______________________________
(PRINT)

REFERRING AGENT SIGNATURE ______________________________ **DATE** ____________

REFERRING AGENT NAME ______________________________
(PRINT)

This authorization for release of information is in effect for a period of one year from the above date.