Options Work Activity Program
7071 Bayers Road, LL05
Halifax, NS B3L 2C2
453-6246
e-mail: info@optionswork.ca

REFERRAL FORM

Please enclose any supporting documentation (i.e. educational reports, medical reports, etc.). Failure to include supporting documentation can delay the applicant's admission.

Personal Information

Name:___________________ ___________________ __________________
(last) (first) (middle)

Address:____
(street) (apt.) (city) (postal code)

Phone:_________________ E-mail:__________________

Marital Status:______ Dependents:______

Source of Income____

Emergency Contact:_______________________ Phone:_________________________

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Referral Source

Agency:____

Name:_____________________________ Position_____________________________

Mailing Address:____
(street) (city) (postal code)

Phone: ____________ Fax:____________ E-mail:______________________________

Length & nature of involvement with applicant__________________________________

Referral client initiated_____ Worker initiated____ Client's level of motivation:_______

____

Functional or other assessments (please attach documentation)______Y _______N

Support Structures

Living Accommodations:_______________________________________

Childcare: Yes_________ No __________ N/A____________

Transportation:___________ Family support:__________

Other persons/organizations who provide support______________________________

Referral Agency's Assessment of Client

Strengths: ____

Weaknesses ____

Caseworker______________________________________ Date_________________

Education History

Last grade completed______ Year________ Type of program____________________

Name of School: ________________________Reason for leaving _________________

Other Academic/Training Programs attended:

Name Program Dates

Does he/she have, or is suspected of having, a learning disability? ___Y ___N

If yes, provide details____

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Employment History (list in order, most recent training first)

Employer Name & Address	Job Title	From	To	Reason for leaving

(please enclose resume, or attach further information on employment)

(Please indicate if the client has any current or past issues with the following:)

Addictions

Does the client have a history of problems with: Gambling ___Drugs____Alcohol_____

Is the client currently receiving treatment? (if yes, please describe) _________________

____

Mental Health History

Diagnosis ____________________________________Date:__________________

Type of treatment ____

Symptoms of recurring illness ____

Restrictions which may pertain to our program_________________________________

Is the client on medication which may affect their participation in a full-time program?__

Psychiatrist/Psychologist ____

Counsellor/Social Worker ____

Legal History

CURRENT: Charges pending _____ On parole______ On probation_______

Please explain the nature of the offenses_______________________________________

____

Record of convictions in the past 5 years ______________________________________

____

____

Physical Health

Please check all that apply:

Physical disability ____ Speech impairment _____
Intellectual disability ____ Hearing impairment _____
Visual disability ____
Other (specify)____
Medications:____

Please explain the above-checked areas and any other physical conditions that may limit your client's ability to work____
____
____

Consent to Refer/Release Information to Options

I, ____, agree to be referred to Options

Work Activity Program and thereby agree that the ______________________________

Agency can release necessary information to the Options Program.

Client's Signature_____________________________ Date______________________

Witness______________________________________