

2065 Henderson Highway

Winnipeg, MB R2G 1P7

T: 204-339-1951 F: 204-334-4173

**MOVING FORWARD**

**Therapy Services Referral Form**

MOVING FORWARD is a fee-for-service program. That means there is a cost for this service. Often the cost of service may be reimbursed through extended health insurance plans (Knowles Centre will provide an official receipt for services). As appropriate, payment may be covered through Dept of Families supports, Jordan’s Principle or other third-party agencies. It is the responsibility of the parent or caregiver to arrange funding. Call 204-339-1955 for more information.

**1. CLIENT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | | | Birth date: |  |
| Address: |  | | | | |
| Phone: |  | Email: |  | | |

|  |  |
| --- | --- |
| Is the youth willing to take part in therapy sessions? | Yes  No  Youth has not been advised of referral yet |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of 1st parent/caregiver or placement: |  | | | | |
| Relationship to child/youth: |  | | | Is parent/caregiver or placement aware of referral? | Yes  No |
| Address if different than above: |  | | | | |
| Phone if different than above: |  | Email |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of 2nd parent/caregiver or placement: |  | | | | |
| Relationship to child/youth: |  | | | Is parent/caregiver or placement aware of referral? | Yes  No |
| Address if different than above: |  | | | | |
| Phone if different than above: |  | Email |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| CFS Status: | Not in care | | Voluntary Placement Agreement | | | |
| Under Apprehension | | Temporary Ward | | Permanent Ward | |
| If client VPA: | Parent: |  | | Phone: | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| If not in care, parents’ status | Single | Common-law | Married |
| Separated | Divorced | Widowed |
| Custody Agreement: |  | | |

**For clients in care or on an extension of care**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CFS worker: | |  | | |
| Agency: | |  | | |
| Agency address: | |  | | |
| Phone: |  | | Fax: |  |
| Email: |  | | | |

**2. REFERRAL INFORMATION (if applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring worker: |  | | |
| Office/Unit: |  | Phone: |  |

**3. REASON FOR REFERRAL**

a. Please identify the main reasons for seeking counselling services. What are the areas that the client wants assistance with?

b. List any relevant symptoms the client is experiencing, e.g., sleep, appetite, concentration problems; mood concerns; regressive behaviours, etc.

c. List any concerning behaviours the client is displaying, e.g, running, substance use, aggression, concerning sexualized behaviours, exploitation, etc.

d. List any medical or psychiatric diagnosis.

e. List any medication presently or previously prescribed.

f. Describe any history of suicidal ideation and/or attempts by client.

g. Are there any current safety concerns.  Yes  No

If yes, please describe:

h. Describe any other self-injurious behaviours, e.g. cutting, burning, head-banging, etc.

i. List any recent sources of treatment, e.g. family doctor, psychiatrist, psychologist, therapist, school counsellor, etc.)

**4. FAMILY INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Mother: |  | Father: |  |
| Describe important info regarding relationship with mother |  | Describe important info regarding relationship with father |  |

Siblings:

|  |  |  |
| --- | --- | --- |
| Name |  | Age |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Describe important info regarding relationship with siblings, if relevant.

Other significant family members or individuals not listed above:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Age |  | Relationship |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Describe important info regarding relationship with others, if relevant.

Describe the strengths of the client and his or her family.

List other agencies currently involved with the client and/or family.

Additional information not otherwise noted.

Social History (if applicable):

*A "social history" will be requested. This is a written account of the client that puts his or her issues or behavior in context. A social history may include aspects of the client’s developmental, family, and medical history, as well as relevant information about life events, demographics, culture, and schooling. It is helpful to help understand their current situation, and to plan for effective treatment and care.*

Social history is being sent with referral.

Social history to be sent later.

Not available.

5. I hereby declare that the above information is accurate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Name (please print) |  | Signature |  | Date |

Please return this referral form to:

Clinical Director

Knowles Centre

2065 Henderson Highway

Winnipeg, MB R2G 1P7

Fax: 204-334-4173

[LHershfield@knowlescentre.org](mailto:LHershfield@knowlescentre.org)

Or call 204-339-1955 for more information.

**THIS DOCUMENT IS CONFIDENTIAL WHEN COMPLETED.**