Lii Michif Otipemisiwak
Family and Community Services

# LMO REFERRAL FORM

## REFERRAL SOURCE INFORMATION

**Date of Referral:** _____

**Referred by** (clearly print full name)**:** _____

**Existing Open File:** ☐ CS ☐ FS ☐ RE ☐ ECD only ☐ CYMH only

**Case Manager:** (clearly print full name) _____

☐ Assessment attached or completed on this form.
☐ Safety Planning Worksheet attached.

## CLIENT INFORMATION

Client & Pronoun (clearly print full name): _____ D.O.B. _____

Address: _____

Telephone: _____

Email Address: _____

**If Client under 19 years, Guardian Contact Info:**

Guardian Name & Pronoun (clearly print full name): _____

Address: _____

Telephone: _____

Email Address: _____

## SERVICES REQUESTED

**Submit all referrals to the Department's Team Leader. Any exception(s) are noted below.**

| | | | |
|---|---|---|---|
| ☐ | Michif Mental Health and Wellness Collaboration | ☐ | Early Childhood Development Support Services |
| | ☐ Early Childhood (ages 0 - 16) | | ☐ Pre-Natal Support |
| | ☐ Youth and Young Adult (ages 16 - 27) | | ☐ Post-Natal Support |
| | ☐ Adult (ages 27+) | | ☐ Infant Development Support (ages 0-3) |
| | ☐ Kinship/Caregiver | | ☐ Childhood Development Support (ages 4-18) |
| | ☐ Family/Couples | | ☐ Direct Support (Childcare Centre) |

☐ Elder (Preference: _____)

☐ Family Finding for Connection and Belonging, and Permanency

☐ Caregiver Support Services (child[ren] placed with kinship or community caregiver)

| ASSESSMENT | | |
|---|---|---|
| **Worry**<br>(What are you most worried about and what is your greatest fear if nothing changes?) | **Existing Strength**<br>(What is the family/youth doing well in relation to this worry) | **Goal**<br>(What do you need to see from the family/youth to feel satisfied that the worry has been addressed) |
| | **Existing Safety**<br>(What has the family/youth done to demonstrate they can address this worry) | |

**SAFETY/WELLBEING SCALE**

| 0 – means things **are not** improving or going well | 10 – means things **are** improving and going well |
|---|---|
| *0 –* | *10 –* |
| What is your number and why? | |
| Scale: 0 ◄——————————————————————► 10 | |
| | |

(Rationale should be in the above assessment in the correct analysis category)

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Person making referral (clearly print full name) | Signature | Date (MMM/DD/YYYY) |
| _____ | _____ | _____ |
| Case Manager (clearly print full name) | Signature | Date (MMM/DD/YYYY) |
| _____ | _____ | _____ |
| Team Leader (clearly print full name) | Signature | Date (MMM/DD/YYYY) |