Thrive Program Referral Form

Date (d/m/y): _____

Name:		Age:
D.O.B:	Gender & Pronouns:	
Phone Number:	Alternate Number:	
MCP #:	SIN #:	
E-Mail Address:		
Street Address:	Postal Code:	
Is the youth aware of the referral?		

If possible please complete this form with the young person.
Please complete as much of this form as you know and as honestly as possible.

This form is used to get a better understanding of an individual's current circumstances. Responses given on this form will not be used for the purposes of excluding individuals from programming.

Living Arrangement

Do you have a safe place to live? **Yes** **No**

What is your current living arrangement? (check one)

- — Living Alone
- — With Family or Friends
- — Group Home
- — Bedsitter
- — Other: Please explain _____

Reason for Referral

_____
_____
_____
_____

Education Status

Have there been any educational assessments completed by the school on you? **Yes** **No**

Describe any learning challenges identified or not identified: _____

_____
_____
_____

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Have you ever had any psychological assessments completed? **Yes** **No**

If yes, please explain. _____

_____

_____

_____

Do you use substances? **Yes** **No**

If yes, please explain. _____

_____

_____

_____

What are you good at? What are your interests?:

_____

_____

_____

Supports

	Name	**Contact Info**
Social Worker		
Child Youth and Family Services		
Corrections		
Addictions		
Housing Support		
Counselling/Psychology		
Community		
Other Schools/ Education Support		
Family Member		
Family Doctor		
Other		
Medical conditions and medications it would be helpful for us to know about:		

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Other Supports

Do you need help getting any of the following?:

- Provincial ID or Driver's Licence (photo ID)
- MCP card
- SIN

Income

What is your source of income? _____

Transportation

How will you get to class? _____

Childcare

Do you have any children?	**Yes**	**No**
If yes, do you have childcare (daycare, parents)?	**Yes**	**No**
If yes, do you have a CSSD file?	**Yes**	**No**

Job/Career Planning

Do you need help with a resume?	**Yes**	**No**
Do you need help with job searching?	**Yes**	**No**
Do you need help with skill building (First Aid/WHMIS)?	**Yes**	**No**

If this is not a self referral, please fill out the following:

Referral Information

Name:	Bus. Phone:	Alternate Phone:
Email:		Fax Number:
When is the best time to contact you?:		

Completed Referral Forms can be returned to us my email, fax, or mail.

Email: apowell@thrivecyn.ca Fax: 709-754-0842 Phone: 709-754-0536 ext. 214 or 709-746-9826

Mail: Thrive CYN PO Box 26067 St. John's, NL A1E 0A5

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Date (d/m/y): _____

Consent for Data Collection

I, _____, give Thrive, CYN, permission to add me to or access the Arms database through my SIN number or other identifying client ID.

Signature (Youth): _____ Signature (Staff): _____

Date (d/m/y): _____

Thrive Program Referral Form

Date (d/m/y): _____

Consent to obtain/release information

I _____ give my permission and consent of my own free will for the gathering/release of information relating to my involvement in and community connections made through **Thrive Programs**.

Thrive staff person(s) is/are granted permission to obtain information from the following organization(s) and/or staff person(s):

Organization	Staff Person(s)

This consent is valid for one year from: _____ to _____

_____ _____

Signature of youth Date (d/m/y)

_____ _____

Signature of Parent/Caregiver Date (d/m/y)

_____ _____

Witness Date (d/m/y)