Thrive Program Referral Form

Date (d/m/y): _____

Name:		Age:
D.O.B:	Gender & Pronouns:	
Phone Number:	Alternate Number:	
MCP #:	SIN #:	
Email Address:		
Street Address:	Postal Code:	
Preferred Contact Method (Call/Text/Email):		

If you are completing this referral on behalf of a young person, we encourage you to do so alongside the individual.

Please complete as much of this form 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.

Reason for Referral

_____
_____
_____
_____

Education Status

What was your last grade completed in school? _____

Do you have any high school credits? **Yes** **No**
If yes, how many credits do you have? _____
_____

Have you had any educational assessment(s) completed? **Yes** **No**
Describe any learning challenges identified or not identified: _____
_____
_____
_____

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Living Arrangement

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

What is your current living arrangement?

- — Living Alone
- — Living with Family or Friends
- — Group Home
- — Bedsitter
- — Shelter

Other: Please explain _____

Other Supports

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 is your source of income? _____

What transportation will you use to get to class? _____

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**

Are there any other things that impact your ability (barriers) to participate in an education program that you would like us to know about?_____

_____

_____

_____

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Support Network

	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:		

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

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

Completed referral forms can be submitted to us by email, fax, mail, or drop off.

Email: apowell@thrivecyn.ca Fax: 754-0842 Mail: P.O. Box 26067, St. John's, NL, A1E 0A5

Office Drop Off: 807 Water Street, St. John's, NL Phone: 746-9826 or 754-0536 ext. 214

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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 (Participant): _____

Signature (Staff): _____

Date (d/m/y): _____

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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 Participant Date (d/m/y)

_____ _____

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

_____ _____

Witness Date (d/m/y)