

John Howard

THE JOHN HOWARD SOCIETY OF THE
CENTRAL AND SOUTH OKANAGAN

Gateway Mentoring Program

Client Referral Form

Gateway Mentoring (FASD) Program is a no fee program, which aims to assist individuals affected by FASD to acquire the essential supports that will allow them to build and maintain healthy lives. Please fill out the referral form as best as you can and submitted it to the below fax number or email address.

Please fax completed referral forms to:
(250) 763-1483 or gatewaycoordinator@jhscso.bc.ca
ATTN: Gateway Mentoring Program

Referral Source Information:

Individual Name(s) of Referral Source(s): _____

Orgnaization(s): _____

Relationship to client: _____

Contact Number: _____ Email: _____

Will the referral source be able to attend an interview with the applicant? YES NO

If not, please suggest an alternate if possible:

Name: _____

Contact number/Email: _____

Individual's Demographics

Name:(First) _____ (Last) _____

Date of Birth: ____ - ____ - ____ (MM-DD-YYYY)

Gender: Male Female

Address: _____

Phone number: _____ Email: _____

ELIGIBILITY CONCERNS:

Was there pre-natal exposure to alcohol? YES NO

Does the client have an FASD Diagnosis YES NO

Who completed the diagnosis? _____

Where? _____

If so, when (Please Approximate if not known)?

Date: ___ - ___ - ____ (MM-DD-YYYY) or approximately _____

Contact number of diagnosing physician? _____

Reason for Referral:

In your opinion how will the client benefit from the program?

Please identify the clients Strength and Weaknesses:

Strengths	Weaknesses
<ul style="list-style-type: none">• _____• _____• _____• _____	<ul style="list-style-type: none">• _____• _____• _____• _____

Criminal Justice Involvement

Does the individual have any pending charges? YES NO

What charges?

Pending Court Dates? (MM-DD-YYYY)

Date: ___-___-____ Date: ___-___-____ Date: ___-___-____

Is the applicant currently on probation? YES NO

Date: ___-___-____ to ___-___-____ (MM-DD-YYYY)

If not on probation or no pending charges do you feel that this client is at risk for contact with police/criminal justice system? YES NO

Why? _____

Medical/Mental Health Concerns

Has the person been diagnosed with a mental health disorder? YES NO

If Yes, please specify what mental health disorders are diagnosed:

If No, please identify any mental health concerns:

Is the applicant currently receiving mental health treatment? YES NO

If yes, please describe treatment plan:

Please list any medications that the individual is taking:

Are there any physical health concerns diagnosed and/or suspected? YES NO

If Yes, please describe health concerns and treatment:

Please describe any other issues or challenges affecting the referred individual not already listed:

Resources and Supports

Is the applicant receiving support from other agencies/organizations? YES NO

If Yes, please list all resources that the applicant is accessing and contact information:

Agency: _____ Contact Person: _____ Contact #: _____

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Does the applicant have family/friend support? YES NO

If yes, please list who they have contact with:

Contact Person: _____ Contact #: _____ Relationship: _____

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Signature of Person Referred

Signature of Referral Source

FOR OFFICE USE ONLY:

CONTACT FOR INTAKE

INTERVIEW REFERRAL NOT ACCEPTED

INTERVIEW DATE: _____ (See attached rationale for explanation)