HAVENS PATHWAY INC.

CONFIDENTIAL CLIENT REFERRAL & SERVICE ASSESSMENT

1 Referring organization and contact

Referring organization / department

Referring worker name and position

Professional email address and telephone

2 Requested service

[ ] Specialized residential care [ ] Respite [ ] Individualized support staffing

[ ] Transitional support [ ] Community-based support [ ] Other

Describe the service requested and desired outcomes

Requested start date, expected duration and urgency

3 Client details

Client full name or secure case identifier

Age / date of birth

Current living arrangement and community of origin

Legal guardian / decision-maker and referral authority

Relevant diagnosis or disability information

Communication preferences, strengths, interests and cultural considerations

4 Daily support and supervision needs

Daily living assistance, routines, mobility and personal care requirements

Required staffing levels, supervision, overnight support and any one-to-one support

School, work, appointments, transportation and community participation needs

5 Health, behaviour and safety planning

Relevant medical needs, allergies and medication-support arrangements

Behavioural support needs, known triggers, de-escalation approaches and successful strategies

Relevant safety considerations, risk management and emergency planning needs

6 Placement context and service coordination

Reason for referral

Existing supports, family/community connections and continuity-of-care considerations

Other agencies or professionals involved

7 Supporting information and declaration

List any assessments or supporting documents available for follow-up

Referring professional name / signature and date

Referral Confirmation

☐ I confirm that this referral is being submitted with the appropriate authorization to share the information provided.