momentum DEVELOPMENTAL SUPPORT

PROGRAM REFERRAL FORM

Please ensure that all fields are completed; attach additional pages as needed identifying the applicable field.

Referral Date (mm/dd/yyyy):	Individual's Name:	
Date of Birth (mm/dd/yyyy):	Age in Years:	☐ Female ☐ Male
MCP#:	MCP Expiry (mm/dd/yyyy):	
SIN #:	AES File # (if applicable):	
Ethnicity:	CRMS File #:	
CSPSW Name:	CSPSW phone number:	
BMS Name:	BMS phone number:	

Region supports are requested to be provided in:

☐ Corner Brook/Pasadena ☐ Metro Avalon (St. John's) ☐ Rural Eastern ☐ St. Anthony ☐ Stephenville

FAMILY/IMPORTANT CONTACTS	Contact 1: Relationship: Phone: Emergency contact? ☐ YES ☐ NO	Contact 2: Relationship: Phone: Emergency contact? ☐ YES ☐ NO
	Other significant adults/children:	

SELECT PROGRAM	☐ Residential Services: Momentum is asked to secure the placement, including housing, in the community either in a group (max of 3 residents) or individualized context. This can be a long term planned admission, or short-term placement.
	☐ Supportive Independent Living: this service is utilized when Momentum is asked to support the resident with living independently in the community with shared staffing resources across one site.
	☐ Emergency Placement: Momentum has a limited number of placement options available to support emergency, or rapid, residential placement. Placement breakdown can happen at any time, and Momentum strives to have options available to meet that demand.

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PREVIOUS PLACEMENT

Previous Placement:

- ☐ Immediate Family
- ☐ Alternate Family Care Home
- ☐ Inpatient Care (MH hospital)
- ☐ Other Relative Home
- ☐ Group Home
- ☐ Other: _____

Caregiver/Contact Name: | **Prev. Placement Start (mm/dd/yyyy):**

Address: | **Phone:**

Reason for termination of previous placement:

MEDICAL

Medication for Resident: ☐ YES ☐ NO | **List Medication(s): (attach to intake form)**

Allergies: ☐ YES ☐ NO | **List Allergies:**

Height: | **Weight:** | **Hair color:** | **Eye color:**

Family Doctor: | **Phone:**

Psychiatrist: | **Phone:**

Medical Diagnosis:

Cognition:

Mobility/Transfers:

Equipment (if applicable):

- ☐ Wheelchair
- ☐ Walker
- ☐ Cane/Crutches
- ☐ Commode
- ☐ Grab Bars
- ☐ Transfer Board
- ☐ Bath Bench
- ☐ Transfer Bar/Pole
- ☐ Hospital Bed
- ☐ RTS
- ☐ Oxygen
- ☐ Lifts

Elimination:

Bowel: ☐ Continent ☐ Incontinent – identify support: _____

Bladder: ☐ Continent ☐ Incontinent – identify support: _____

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IDENTIFYING PROBLEMS		MENTALH HEALTH DIAGNOSES		BEHAVIORAL PROBLEMS		LEGAL ISSUES (ensure copies of any court documents are attached to intake)	
Substance Abuse	☐	Intellectual disability	☐	Oppositional	☐	Theft	☐
Sexual Abuse	☐	Psychosis	☐	Explosive Disorder	☐	Assault	☐
Suicidal Ideation	☐	Depression	☐	Impulse control	☐	Trespass	☐
Suicidal Gestures	☐	Anxiety	☐	Assaultive	☐	Molest	☐
Self-harm	☐	Adjustment to trauma	☐	Verbally abusive	☐	Burglary	☐
Physically abusive	☐	Other (Specify):	☐	Obsessive behaviors	☐	Weapons	☐
Physically abused	☐			Smoking	☐	Vandalism	☐
Gang affiliations	☐			Sexually aggressive	☐	Battery	☐
Hospitalization	☐			Fire setting	☐	Arson	☐
Health problems	☐			Other (Specify):	☐	Other (Specify):	☐
Physical limitations	☐						
Other (Specify):	☐						

Please elaborate on any of the above identified problems or issues:

Identify any potential sources of trauma (physical abuse, neglect, etc.):

Any other important notes not already captured?

LEVEL OF CARE	Identify the recommended level of support for the referred resident: ☐ 2-on-1 staffing. **Rationale:**
	☐ 1-on-1 staffing. **Rationale:**
	☐ Reduced staffing ratio (i.e. shared staffing resources in a group context, resident able to be left alone for extended periods; please specify in the rationale). **Rationale:**
	☐ Request for Momentum to identify recommendation of staffing ratio, based off client profile information.

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Consent & Referral Source Information

I, _____ (print name), have provided this information regarding

_____ (Name of client) to Momentum to the best of my knowledge.

Name	Title/Role (SW, parent, etc.)	Signature	Date of signature (mm/dd/yyyy)

Phone number	Fax number	E-mail