

**ACCREDITED SUPPORTIVE LIVING SERVICES**  
**FAMILY SUPPORT REFERRAL**

**Name and Personal Details**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
                    First                      Last                                      Day    Month                      Year

Alberta Health Care No: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Address: \_\_\_\_\_  
                    Street/Box #                                      Town                                      Province                                      Postal Code

Phone Number: \_\_\_\_\_ Alternate # \_\_\_\_\_

**Contact Person (Parent or Legal Guardian)**

**Siblings**

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the child's disability/diagnosis:

(Note: If the child has not been medically diagnosed as having a disability, please provide documentation as to why you feel he/she has one. For example, if the school has done an assessment or has reported behaviors, displayed by the child, that leads them to suspect a disability, please include this information and/or your observations.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reasons for referral and/or services/supports desired:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What services/agencies have you utilized in the past or are presently receiving service from (e.g. Outreach, Mental Health, Home Care, etc.).

Service/Agency	Check if currently	Support Provided	Contact Person
_____			
_____			
_____			
_____			

Referring Agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Family Self Referral: Yes: \_\_\_\_\_ No: \_\_\_\_\_

If self referral, how did you hear about the Accredited Supportive Living Services?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed By: \_\_\_\_\_

Date: \_\_\_\_\_