



ACCREDITED SUPPORTIVE LIVING SERVICES
REFERRAL

Community Access for People in Continuing Care
(CAPCC)

1. Name and Personal Details

Name: _____ Date of Birth: ____/____/____
First Last Day/Month/Year

Alberta Health Care No.: _____ Family Doctor: _____

Address: _____
Street/Box No. Town Province Postal Code

Phone Number: _____ Alternate Number: _____

Contact Person (Parent or Legal Guardian)

1. _____

2. _____

Referred By: _____ Phone Number: _____

Living Situation

2. Medical

Doctor's Name: _____ Phone Number: _____

Diagnosis: _____

Comments: _____

Identify behavior/ disciplinary problems: None: _____ Occasional: _____ Frequent: _____

If behavior or disciplinary problems exist, please describe in detail (intensity, frequency, location):

3. Socialization and Community Skills

Interpersonal Relationships:

Interacts with others: _____

Minimal but appropriate interaction: _____

Interacts with others but inappropriately: _____

Comments

4. Supports and Services Needed

Please describe the type of support and/or services you feel the individual requires:

Completed by: _____

Date: _____

PLEASE SUBMIT TO:

Richard Harriman, CAPCC Program Coordinator

#205 10006 – 101 Ave. Grande Prairie, AB T8V 0Y1

Phone : 1-877-539-0433 Ext. 126

Fax : 1-780-538-2946

Email : richard.harriman@aslimited.org