GOOD SHEPHERD
Creative Works Studio Referral Form

Referral Source: Name/ Organization/ Program	**Date of Referral:** _______________ **Contact #:** ____________________

CLIENT INFORMATION		
First Name:	**Last Name:**	
Preferred Name:	**Date of birth:**	**Age:**
Phone Number:	**Email:**	
Address:		
City:	**Postal Code:**	

Gender:
[] Female [] Trans Woman [] Two-Spirit [] Gender Fluid [] Genderqueer
[] Male [] Trans Man [] Intersex [] Non-Binary [] Gender Non-Conforming [] Prefer not to answer
[] Other: ________________________
Pronoun(s):

Ethnic Identity:

Do you speak English: [] Yes [] No	**Preferred Language(s):**

Are you currently employed or volunteer?
[] Yes [] No If yes, Where:

Do you have Accessibility and/or Mobility Concerns?
[] Yes [] No If yes, please specify:

EMERGENCY CONTACT INFORMATION	
First Name:	**Last Name:**
Phone Number:	**Alternate Phone Number:**
Relationship:	**Can a message be left at the number(s) provided?** [] Yes [] No

MEDICAL INFORMATION

Do you have any allergies? [] Yes [] No
If yes, please specify:

Healthcare Professionals:
Name: __________________________________ **Type:** ______________________________ **#** ___________________________
Name: __________________________________ **Type:** ______________________________ **#** ___________________________
Name: __________________________________ **Type:** ______________________________ **#** ___________________________

Do you have any Physical Health Diagnoses [] Yes [] No If yes, please specify:
Do you have any Mental Health or Psychiatric Diagnosis? [] Yes [] No If yes, please specify:
Are you currently prescribed Medications? [] Yes [] No If yes, please specify:
Please describe your substance use, if any?
COMMUNITY RELATIONS
Are you connected with other Agencies, Services or Programming in the community? [] Yes [] No If yes, please specify:
Have you had any involvement with the legal system in the past year? [] Yes [] No If yes, please specify:

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MOVEMENT
Do you have any challenges with movement and activities that might take up to 1 hour? Movements may include: Painting, Drawing, Movement Exercises. **What assistance or modifications might you require that would help you participate in activities?** **Do you feel you have any barriers that would prevent you from engaging in regularly scheduled activities?** **If Yes, what would be helpful in overcoming those barriers?**
ENGAGEMENT
Do you prefer working on activities alone or in a group? **What kind of emotions might you experience while working with others in a group?**

STAFF COMPLETION
Referral Reviewed by: ____ Date: ____________________________ Client Start Date: __________________________

To refer yourself or another person to the program, please submit this form to:

Ximena Moreno xmoreno@gsch.ca

f. 416-203-2811

For more information, please call:

p. 416-203-2711 x 4255