STONE HEARTH BAKERY
SKILLS TRAINING PROGRAM
LL05 - 7071 Bayers Rd Halifax, NS B3L 2C2
Phone: (902) 454-2851
Fax: (902) 453-4793
Email: referralSHB@mymetroworks.ca

REFERRAL FORM

Completed by: _____ Date:_____

Please ensure all fields are completed: failure to provide all requested information can delay applicant's admission.
Completed form can be faxed or emailed to the attention of Brittany Benedict.

APPLICANT INFORMATION

First Name:	**Last Name:**
Address: **Apartment:**	**City:** **Postal Code:**
Phone Number:	**Email:**
Please describe the applicant's living arrangements (supported housing, independent, w/family, etc. AND whether or not this is stable):	
Birthdate (Month/Day/Year):	
SIN:	**NS Health Card:**
Emergency Contact (Name, Phone # and the relationship to applicant):	
Education (highest level completed):	**Has the applicant attended the Stone Hearth Program in the past?** ❑ Yes ❑ No
Marital Status:	**# of Dependents:**
Allergies (include severity):	

REFERRAL'S ASSESSMENT AND INFORMATION

If other assessments are available, please attach copies to the application.

Referring Agency & Name:	
Phone:	**Email:**
Length & Nature of Involvement:	
Who initiated the referral, and why?	
Level of motivation:	
What is the applicant looking for from the Stone Hearth Bakery Program?	
Strengths of Applicant:	**Weaknesses of Applicant:**

Does the applicant identify as having a disability?

❑ None ❑ Physical ❑ Intellectual ❑ Visual ❑ Speech ❑ Hearing ❑ Learning ❑ ADD/ADHD

❑ Dexterity ❑ Mobility ❑ Developmental ❑ Cognitive ❑ Mobility ❑ Mental Health ❑ Other

Please explain any diagnosis and ongoing symptoms we should be aware:

Is the disability considered episodic?

Is the applicant on medication to treat anything checked above? Please list any side effects this may cause:

Is there a history of addiction? ❑ No ❑ Gambling ❑ Alcohol ❑ Drugs ❑ Other

If yes, please explain treatment plan:

Has the applicant ever had an aggressive outburst? ❑ Yes ❑ No

History of violence? ❑ Yes ❑ No

Please describe:

COMMUNITY SERVICES INFORMATION

Case Workers and Care Coordinators will be contacted for approval of applicant's participation prior to being accepted into the Stone Hearth Bakery Program.

Case Worker Name:	**Income Assistance // Disability Support Program** (Please circle)
Phone:	**Email:**
Employment Support Services: **Phone:**	**Email:**

LEGAL HISTORY

Please Check One:

❑ No criminal record ❑ Charges Pending ❑ On Parole ❑ On Probation ❑ Other:

Please explain the nature of the offenses and any conditions:

_____

_____

EMPLOYMENT/VOLUNTEER HISTORY

Please list employment, volunteer or other program experience, in order of most recent:		
COMPANY & TITLE	**DATES**	**REASON FOR LEAVING**

SUPPORT SYSTEMS

Persons provided may be contacted prior to acceptance and during applicant's program experience. Please make a note of anyone who would want ongoing contact, including family, housing support, case worker, referral source, or other supporting organizations.

Medical	
Name:	**Organization:**
Phone:	**Email:**
Notes:	
Family or Personal	
Name:	**Organization:**
Phone:	**Email:**
Notes:	
Housing or Community	
Name:	**Organization:**
Phone:	**Email:**
Notes:	
Other	
Name:	**Organization:**
Phone:	**Email:**
Notes:	

RELEASE OF INFORMATION

I, _____, agree to be referred to Stone Hearth Bakery's Work Adjustment Skills Training Program. Therefore, I agree that the agency or person making the referral, can release and request information from my file that is relevant to my participation in the program.

Applicant's Signature: _____ Date: _____

Referral's Signature: _____ Date: _____