



# Healing Steps

Family Services Inc.

*Every journey to healing begins with a first step*

Regina / Saskatoon, Saskatchewan

Tel: +1 639 554 7221 | Email: referrals@healingstepsfamilyservices.com

## Referral for Services

ALL INFORMATION MUST BE  
COMPLETED FOR SERVICE

Date Request Made: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

## Service Request :

Transportation

Visitation

Full time In Home Support

Healing Steps

Supervised

Monitored

Home

Supervised

Monitored

MSS

Supervised

Monitored

Other

Supervised

Monitored

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## Section 1 – Contact Information – Worker:

Name: \_\_\_\_\_ Unit: \_\_\_\_\_

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

## Supervisor:

Name: \_\_\_\_\_ Unit: \_\_\_\_\_

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

## Section 2 – Primary Visitors:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

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Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

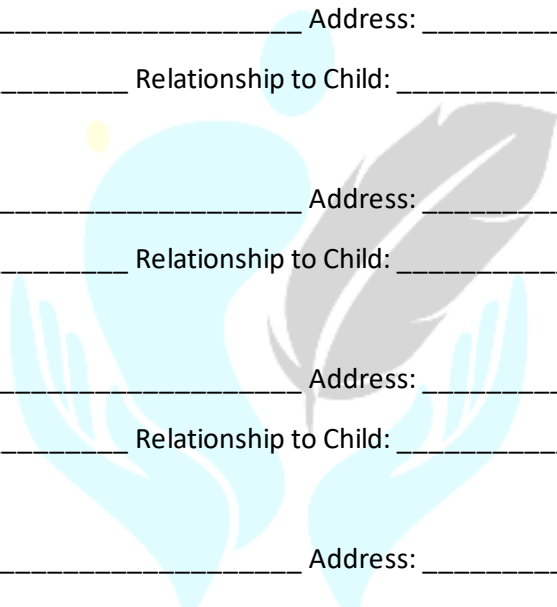
Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_



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### Section 3 – Child(ren):

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Person ID: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Card No: \_\_\_\_\_

Transportation: Healing Steps  Caregiver  Cab  Other

Additional Information:

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Person ID: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Card No: \_\_\_\_\_

Transportation: Healing Steps  Caregiver  Cab  Other

Additional Information:

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Person ID: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Card No: \_\_\_\_\_

Transportation: Healing Steps  Caregiver  Cab  Other

Additional Information:

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Person ID: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Card No: \_\_\_\_\_

Transportation: Healing Steps  Caregiver  Cab  Other

Additional Information:

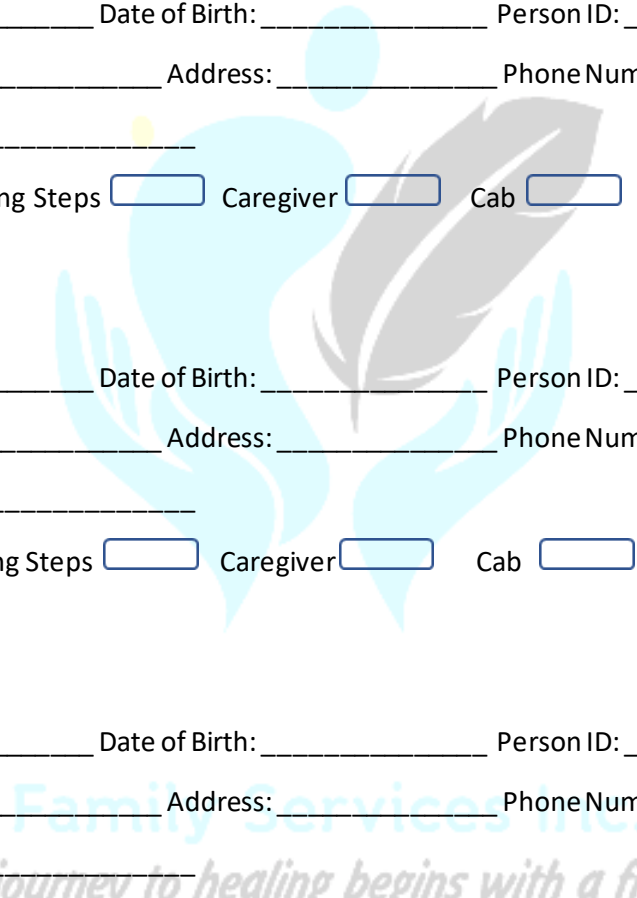
Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Person ID: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Card No: \_\_\_\_\_

Transportation: Healing Steps  Caregiver  Cab  Other

Additional Information:



**Section 4 – Visit Details:**

Address/Location of visit: \_\_\_\_\_

Number of Visits Per Week: \_\_\_\_\_ Length of Each Visit: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Day/s of the week: \_\_\_\_\_

Visitor Check in Required  Time of Check in: \_\_\_\_\_

1. Special Instructions/ Other Pertinent Background/Information/Awareness (ei: Domestic Violence, Gang Affiliation, Alcohol/Drug use, Mental Heath, etc) Please specify:

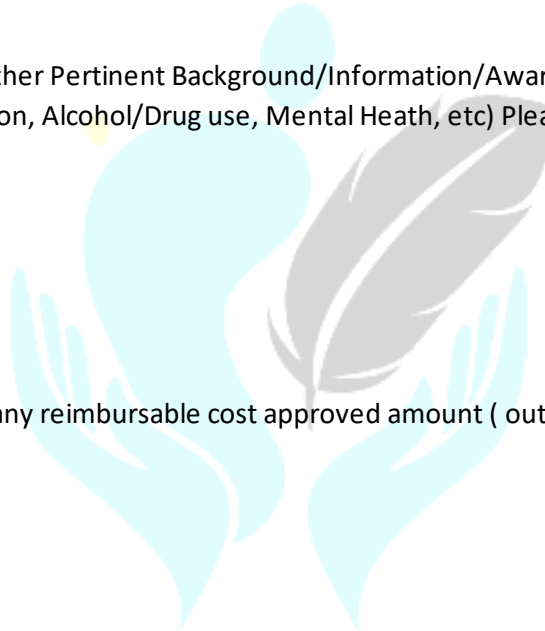
2. Please state if there is any reimbursable cost approved amount ( outings, meals, family bonding activities, etc.):

Approved? Yes:  No:  On which date: \_\_\_\_\_

CPW contacted with reply? Yes: No:

Date: \_\_\_\_\_ Healing Steps Signature: \_\_\_\_\_

(Note: MSS needs to notify Healing Steps of any changes and cancellation of contract.)



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