



Central Urban Métis Federation Inc.
1075 Kensington Blvd.
Saskatoon, SK
S7L 7P4

AggiesandShirleys@sasktel.net

Phone: (306) 249-5850

Fax: (306) 249-5855



REFERRAL

Date of Referral: _____

Staff Initials: _____

- | | |
|---|--|
| ☐ Self-Referral | ☐ Hospital Referral |
| ☐ Justice Referral | ☐ Agency Referral |
| ☐ Outreach Worker Referral | |

Urgency Level:

- ☐ Immediate (within 24 hrs)
☐ Within 48 hrs
☐ Within 1 week

SECTION 2: REFERRAL SOURCE (If Agency)

Agency Name: _____

Contact Person: _____

Title: _____

Phone: _____

Email: _____

Has the client consented to this referral?

- ☐ Yes (written consent attached)
☐ Yes (verbal consent)
☐ No

SECTION 3: APPLICANT INFORMATION

Legal Name: _____

Chosen Name: _____

Pronouns: _____

Date of Birth: _____

Age: _____

Safe Phone: _____

☐ OK to leave voicemail ☐ NOT safe

Safe Email: _____



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Status (voluntarily disclosed):

☐ Métis ☐ First Nations ☐ Inuit

Band/Community (optional): _____

Phone: _____

Current Situation:

☐ Unsafe housing ☐ With abuser ☐ Couch surfing ☐ Hospital ☐ Other: _____

Is it safe for staff to contact or visit previous address?

☐ Yes ☐ No ☐ Do not disclose

Current Location:

☐ Unsafe housing ☐ With abuser ☐ Couch surfing ☐ Hospital

☐ Other: _____

Current Location: _____

Where did you sleep last night? _____

Previous Address:

Duration of abuse: _____

Current Safety Situation:

Are you currently safe? ☐ Yes ☐ No

Brief description of situation (keep short):

Duration of abuse: _____

Most recent incident: _____

Is the person causing harm aware you are leaving?

☐ Yes ☐ No ☐ Unsure



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Any immediate safety risks:

Immediate risk factors:

- ☐ Threats with weapons
- ☐ History of strangulation
- ☐ Escalating violence
- ☐ Stalking
- ☐ Abuser has access to firearms
- ☐ Suicide threats by abuser

Is the applicant currently fleeing violence from abuser?

- ☐ Yes
- ☐ No

Type of violence experienced (check all that apply):

- ☐ Intimate partner violence
- ☐ Sexual violence
- ☐ Human trafficking
- ☐ Financial abuse
- ☐ Emotional / coercive control

Are there any known safety concerns involving:

- ☐ Gang involvement / affiliation
- ☐ Community retaliation risk
- ☐ High-risk associates connected to situation

Is there an active restraining/protection order?

- ☐ Yes
- ☐ No

Children or dependent Information:

Are there children or dependents connected to this referral?

- ☐ Yes
- ☐ No

If yes:

Number of children/dependents: _____



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For each child/dependent (attach additional sheet if required):

Child Name	Age	Accompanying Applicant	Special Needs/Medical/Safety Concerns:

Is there current child protection involvement?

- ☐ Yes
☐ No
☐ Unknown

Medical and medication information:

Primary Care Provider: _____

Current Medications (attach list if needed):

Does the applicant require medication storage support?

- ☐ Yes
☐ No

Allergies: _____

Chronic health conditions: _____

Pregnant?

- ☐ Yes
☐ No
☐ Prefer not to say

Mental Health concerns or diagnosis

Mental health diagnoses (if known):



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Recent hospitalization (past 30 days)?

- ☐ Yes
☐ No

Suicide risk:

- ☐ Current ideation
☐ Past attempt
☐ No known risk

Substance use (optional disclosure):

- ☐ Alcohol
☐ Opioids
☐ Methamphetamine
☐ Cocaine
☐ Cannabis
☐ Other: _____

Mental health supports needed: _____

Accessibility needs: _____

LGBTQ2T+ AFFIRMING SUPPORT NEEDS

☐ N/A

Gender identity: _____

Is applicant on hormone therapy?

- ☐ Yes
☐ No
☐ N/A

Does applicant require:

- ☐ Name change support
☐ Legal ID support

Any safety concerns related to gender identity?

- ☐ Yes
☐ No



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Housing and Transitional Planning:

Income source:

- ☐ Employment
- ☐ Income Assistance
- ☐ Disability
- ☐ None
- ☐ Other: _____

ID Available?

- ☐ Birth Certificate ☐ Status Card ☐ Health Card ☐ SGI ☐ None

Goals during 30-day stay:

- ☐ Secure longer-term housing
- ☐ Safety planning
- ☐ Legal support
- ☐ Counseling
- ☐ Income stabilization
- ☐ Treatment referral
- ☐ Reunification support

☐ Other: _____

CONSENT

I consent to the sharing of relevant information for the purpose of intake, safety planning, and case coordination.

Applicant Name: _____

Signature: _____

Date: _____

Witness/Staff: _____

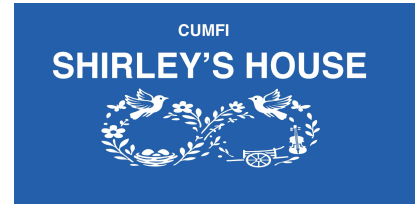


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ELIGIBILITY SCREEN (Internal Use Only) completed by: _____

☐ Age eligible

☐ DV verified

☐ Indigenous

☐ LGBTQ2T+ identified or affirming space requested

☐ Medically stable

Bed Availability:

☐ Accepted

☐ Waitlisted

☐ Referred elsewhere

Director: _____

Date: _____

Assigned suite: _____

Notes: