YWCA TURNING POINTS PROGRAM
510, 25th Street East
Saskatoon, SK
Phone: 244-7034 ext. 857
Fax: 244-3078
Email: tpoints@ywcasaskatoon.com

Please contact the Turning Points Program monthly to keep name the on the list

APPLICATION FORM

Client must be 18 years of age or older to access the services of the Turning Points Program

CLIENT INFORMATION

SURNAME: ______________________ First: ______________ Alias: ___________

DOB (dd-mm-yy) ____________________ PHN: ______ ______ ______ SIN: _____ _____ _____

Contact phone number: _______________

REFERRAL INFORMATION

Date of Referral: ________________

Referred by: ________________________ Relationship: ____________________

Agency: ____________________________ Contact #: ______________________

CLINICAL INFORMATION

What is the clients medical diagnosis: ____

____

____

____

CURRENT MEDICATIONS:

	Type	Dose
1.	________________	________________
2.	________________	________________
3.	________________	________________
4.	________________	________________
5.	________________	________________

CLINICAL FEATURES: *(Please check all that apply)*

- ❑ Depression
- ❑ Psychotic Symptoms
- ❑ Manic / hypomanic Symptoms
- ❑ Long standing Significant relationship problems
- ❑ Drug / alcohol abuse
  What? ____________________
  How often? ____________________
- ❑ Inability to cope with life stressors
- ❑ Anxiety / Panic / Agitation
- ❑ Obsessive / Compulsive behaviours
- ❑ Behavioural issues (i.e. conflict, anger)
  What? ____________________
  ____

CLINICAL INFORMATION cont'd

ACUTE CARE SERVICES: (Includes Emergency room and Psychiatric visits)

Number of times accessed during one week: __________ Type of service: ____

Main reasons: ____

____

Additional notes:

____

____

PRESENT HOUSING SITUATION:

- ❑ Apartment
- ❑ Mental Health Approved Home
- ❑ Group Home
- ❑ Others
- ❑ Saskatoon Housing Authority
- ❑ Care Home
- ❑ YWCA Crisis Shelter
- ❑ Family / Friends

Address if available: ____

SOURCE OF INCOME:

- ❑ Ministry of Social Services
- ❑ Trustee
- ❑ Pension
- ❑ Employment Insurance
- ❑ Employed
- ❑ School funding
- ❑ Band funding
- ❑ Disability
- ❑ Other ____

____

____

LIFE SKILLS: (Rate the following from 1 – 10 : 1 is the lowest and 10 is the highest)

_____ Self-esteem

_____ Time Management

_____ Personal Hygiene

_____ Positive thinking

_____ Coping skills for dealing with loss, abuse, trauma

_____ Assertiveness

_____ Dealing with grief and anxiety

_____ Relaxation techniques / Exercise

_____ Managing Conflict

_____ Anger management

_____ Finance Management

_____ Cooking and nutrition

_____ Communal Living

COMMUNITY / SOCIAL SUPPORT: (i.e. family, friend, landlord, professional)

Name	Relationship	Phone #

CLIENT GOALS:

What are the client's short term goals – over the next 2 months?

____

____

____

____

What are the client's long term goals – over the next 12 months?

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REASON FOR ACCESSING THE TURNING POINTS PROGRAM:

Why does this person need the support of the Turning Points program?

____

____

____

____

How do you think they would benefit from the Turning Points program?

____

____

____

____

CLIENT ACKNOWLEDGEMENT

I ___________________________________ acknowledge that the information provided on this form is true and accurate.

________________________________	________________________________	____________________
Clients Name (please print)	Clients signature	Date
________________________________	________________________________	____________________
Signature of referee (please print)	Referee signature	Date

OUTCOME OF APPLICATION:

☐ **ACCEPTED** into the Turning Points Program: Date: ________________________________

When did the client arrive at the YWCA? (dd-mm-yy) ________________________________

☐ **DENIED** access to the Turning Points program: Date: ________________________________

Reason client was denied: ____

COMMENTS: