

Visions Employment Inc.  
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## **Referral Form**

The following criteria must be met before Visions Employment Inc. can proceed with an Intake.

- Provide written documentation of primary diagnosis of a developmental disability by a Physician or Registered Psychologist
- Provide Certificate of Conduct and Vulnerable Sector Check
- Ready and willing to work
- Upon securing employment transportation is the responsibility of the caregiver/family member
- Must provide copy of SIN, MCP card and Birth Certificate

Full Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M \_\_\_ F\_\_\_

SIN: \_\_\_\_\_ MCP: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

Parent/Caregiver Name(s): \_\_\_\_\_ Phone #: \_\_\_\_\_

Alternative contact in case of emergency: \_\_\_\_\_

Alternative # in case of emergency: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Location: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other Involved Professionals: \_\_\_\_\_

Primary Diagnosis (Developmental Disability): \_\_\_\_\_

Secondary Diagnosis (if applicable): \_\_\_\_\_

Name of Last School Attended: \_\_\_\_\_

Location: \_\_\_\_\_

Highest Grade Completed: \_\_\_\_\_

Other Training Received: \_\_\_\_\_

Previous Work Experience (Paid or Volunteer):  
\_\_\_\_\_  
\_\_\_\_\_

Have any Assessments been done on this individual? Yes\_\_ No\_\_ If YES, Please provide contact information.

Name: \_\_\_\_\_ Tel. No: \_\_\_\_\_

Pertinent issues/behaviours that could impact employment such as Health/Medication, etc.  
\_\_\_\_\_  
\_\_\_\_\_

Able to provide Certificate of Conduct? Yes\_\_ No\_\_

Referral Made By: \_\_\_\_\_ Contact #: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_