Manitoba

Referral for Support Intensity Scale (SIS) Assessment
Community Living disABILITY Services (CLDS)

Date of referral	
Participant Name	
Birth date	
InFACT ID #	
Referral Made By (include position title)	
Reason for SIS Referral	
Participant Address	
Region/Community Area	
Has the participant had a SIS assessment before? If yes, date of previous assessment	
Is the participant and/or support network aware that a referral has been made for a SIS assessment? If no please provide details:	

Names of those to be invited and Recommended respondents for the SIS:	Relationship to Participant/Agency/Role:	Notes:
Remember: Representation from across environments (family, home, work, day program, community, etc.) is important. Respondents need to know the individual well (observed in one or more environments for at least 3 months) Also, if the individual is unable to participate, it is required for the interviewer to meet the individual prior to the SIS interview (arrangements for this will be made in the least intrusive and most convenient way for the individual).	Remember: SDM(s)/family must be informed of the interview prior to it happening and if they have expressed they would like to attend, the meeting should not proceed without them (unless the individual has specifically requested that family not be involved in the assessment process or family has not been actively involved in the individual'slife).	
Name: Contact information:	Relationship to participant:	Notes:
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Name: **Contact information:**	**Relationship to participant:**	**Notes:**
Family Contact Information:		
SDM or PGT Information:		
Program Status: Intake ☐ Eligible ☐ **Intake Contact or CSW:**	**Notes:**	

Received By	
Date Received	Click here to enter a date.
Assigned to SIS Facilitator to schedule the SIS Assessment	
Will not be forwarded for a SIS assessment and Reason	
Referral Source Notified of outcome of referral and date of notice	