TurningPoint

General Program Information: 236-877-2649
Email this completed form to:
jgracey@turningpointrecovery.com

NAME _____
LAST FIRST

Date of Birth ____ / ____ / ____ **Current Age** _____
DD MM YY

TPOCC PROGRAM REFERRAL FORM

THIS FORM IS NOT A REFERRAL FOR TURNING POINT RESIDENTIAL RECOVERY SERVICES

TPOCC is for patients/clients who are at risk of opiate overdose and need help accessing:

- Short term counselling (10-12 Sessions) while waiting for another program
- Support with pre-admission requirements for treatment programs
- Referrals to other government or community service programs

PART 1 – PERSONAL INFORMATION

Preferred Name (aliases/nicknames) _____

Personal Health # _____

Gender Identification _____ **Ethnicity** _____

Other Language(s) _____ _____

Contact # 1 _____ 2 _____ Message ☐ Yes ☐ No

Housing Status Home Owner ☐ Renting ☐ Homeless ☐ Staying with family ☐ Staying with friends/others ☐

Address/ Location _____

Income Status Employed ☐ Employment Insurance ☐ Pension ☐ Income Assistance ☐ EI / IA / PWD /CPP-D Pending ☐

PART 2 – BACKGROUND

Reason for Referral:

In Detox ☐ Pregnant ☐ Homeless ☐ HIV+ /Other Health Issues ☐

Other Crises _____

Safety Concerns / History or Current Violence

Suicide Risk? Yes ☐ No ☐

General Comments (Eg. Client preferences, triggers, etc.)

Referral Information

Referred by:_____ Agency:_____

Referee Contact Phone:_____ Referee Contact Email:_____

Is client aware of referral? Yes ☐ No ☐ Would you like us to contact you to discuss this case? Yes ☐ No ☐