TurningPoint

OUTREACH PROGRAM REFERRAL FORM

THIS FORM IS NOT A REFERRAL FOR TURNING POINT BED BASED RECOVERY SERVICES

PART 1 – PERSONAL INFORMATION

Legal First Name _____ **Legal Last Name:** _____

Preferred Name or Alias:_____ **Gender Identification:**_____

Age:_____

What is the best way to contact this person? Please list phone/email below in order of preference. Clinicians or other support staff can also be contacts.

Contact #1 (phone or email address):_____

Contact #2 (phone or email address):_____

Income Status Employed ☐ Employment Insurance ☐ Pension (including CPP, OAS/GIS) ☐ Basic Income Assistance ☐

PWD ☐ CPP-D ☐ No income source ☐ Other Income Source ☐

Consent. We work closely with partner agencies to help coordinate services. Do you consent to sharing this information?

☐Yes ☐Yes, except the following agency (agencies):_____

Client Signature:_____ Date:_____

OR ☐ Verbal Agree. Staff Name:_____ Date:_____

PART 2 – SERVICE PLANNING

Where are you living right now?
Street/Tent/encampment/Vacant Building ☐ Vehicle ☐ Staying with others and NOT paying rent ☐

How Long Have You Been in Richmond?
_____ # Days _____ # Weeks _____# Months _____# Years

Which of the following are of interest in accessing?
Bed-based Substance Use Treatment ☐ Private Market Housing ☐ Shelter ☐
Supportive Housing☐ Return to family/other community ☐

Are you connected to any of the services below?
VCH – Anne Vogel Clinic ☐ VCH - ACT ☐ VCH - Other ☐ Other:_____

PART THREE – REFERRAL INFORMATION

Referred by:_____ Agency:_____

Contact Phone:_____ Contact Email:_____

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

PART FOUR – OTHER NOTES