The Service Coordination Project for Homeless People Living with HIV/AIDS

Referral Form

Client Full Name ______________________________ D.O.B. dd/mm/yyyy

Current Housing Situation ____

Address (or mailing address) ____

Patient's cell phone/contact number (if any) ____________________________

Name of partner/friend __________________ Relationship ________________

Partner/friend's phone number(s) ____________________________________

OHIP________________________VC____ SIN__________________________

Gender: Female ( ), Male ( ), Trans Female ( ), Trans Male ( )

Source of Income____

ODSP ☐____________________OW ☐ CPP ☐ Private Disability ☐

Client is ☐Canadian Citizen, ☐ Landed Immigrant, ☐ Refugee/Protected Person or ☐ Refugee Claimant.

Referring Agency ____

Contact Name _________________________Contact# ____________________

Referral Reason ____

____

If the Referral source is a Hospital please attach the Discharge Paperwork.

Health

Immediate Health Concerns ____

____

____

Health Conditions (HIV/AIDS, Hepatitis, Diabetes, TB, Etc) _________________

____

Last TB testing date: _____________________ Results: __________________

Hospitalizations in the last six months

Hospital Name ________________________ length _______________________

Reason____

Hospital Name ________________________ length ______________________

Reason____

Family Dr's Name_______________________ Phone #___________________

Address ____

Specialist Name________________________ Phone #___________________

Address___________________________ Spec. Area _____________________

Specialist Name________________________ Phone #___________________

Address___________________________ Spec. Area _____________________

Medication Regimen (1 HAART. 2 Mental Health Meds. 3 Others)

1. ____
2. ____
3. ____

Drug allergies (if any) ____

Primary Pharmacy Name_________________ Address___________________

Mental Health Diagnosis ___________________ ______________________

Currently on treatment: Yes____, No ____. If yes where ___________________

Substance/Alcohol Use______________ ______________ _____________

Currently in treatment: Yes ___, No ___. If yes where _____________________

Substance/ Alcohol Use Frequency ____________________________________

____

Legal Involvement: Yes_____ No____ (Comment if yes) __________________

____

Emergency Contact ________________ Phone #________________________

Address____

Next of Kin _______________________ Phone# ________________________

Address____

___________________________ ___________________________

Client Printed Name Client Signature

___________________________ ___________________________

Referral Agent Printed Name Referral Agent Signature

Date (dd/mm/yyyy) ____ / ____ / _______