Community Support Referral Form

Please return this form by fax to 905-225-1279 or email admin@reachniagara.com

Client Information

First Name:_____ Last Name: _____

Date of Birth (DD/MM/YYYY):_____ Phone: _____ Gender:____

Address: _____ City: _____

Postal code: _____

Referral Source Information

Name:_____ Phone: _____ Fax:_____

Name of Agency: _____ Email: _____

Client requires support with the following: (check all that apply):

- ☐ Primary Care
- ☐ ODSP Application
- ☐ ODSP Appeal
- ☐ System Navigation (i.e., financial connection, community referrals, etc.)
- ☐ Identification assistance
- ☐ Mental Health Counseling
- ☐ Substance Use Counseling
- ☐ Addiction Support
- ☐ Other:_____

History of or current substance use: ☐ YES ☐ NO

If applicable, please select the program of interest: ☐ PATH ☐ JSTICE

Source of Income:

- ☐ Ontario Works
- ☐ ODSP
- ☐ CPP
- ☐ Employment
- ☐ Old Age Security (OAS)
- ☐ Other:_____

Consent (Please Review and Initial)

- ☐ Client has verbally consented to the disclosure of their personal health information for the purposes of a referral to REACH Niagara
- ☐ Email only - I understand that email is not a secure means of communication and understand the risks. REACH's privacy statement can be reviewed at: https://reachniagara.com/about/privacy-policy/.