



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: _____ Birthday (DD/MM/YYYY): _____

Phone: _____ Gender: _____ Address: _____ City: _____

HIFIS # (if known): _____ OW/ODSP Member ID (if known): _____

Referral Source Information

Name: _____ Phone: _____ Fax: _____

Name of Agency: _____ Email: _____

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

☐ Primary Care

☐ Identification assistance

☐ ODSP Support

☐ Mental Health or
Substance Use Counseling

☐ System Navigation (i.e.
financial connection,
community referrals, etc.)

☐ Addiction Support

☐ Exiting shelter (i.e. newly
housed, on restriction,
homelessness)

If applicable, please select the program of interest:

☐ JUSTICE ☐ PATH

☐ Primary Care Street Outreach Team

Source of Income:

☐ Ontario Works

☐ CPP

☐ Old Age Security (OAS)

☐ ODSP

☐ Employment

☐ Other: _____

Additional Information:

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/>