Hands FamilyHelpNetwork.ca Mains LeReseaudaideauxfamilles.ca

CLIENT REFERRAL FORM

For office Use Only

File #

THIRD PARTY REFERRAL FORM

All fields below must be printed and completed. Incomplete requests may cause a delay in the referral process.

NAME OF CLIENT: _____ D.O.B: _____

NAME OF PARENT/LEGAL GUARDIAN:_____

ADDRESS:_____

PHONE NUMBER: (H)_____(W) _____

REFERRAL SOURCE: _____

ADDRESS:_____

PHONE NUMBER: _____

REASON FOR REFERRAL AND TYPE OF SERVICES EXPECTED:

_____

_____

_____

_____

KNOWN MEDICAL PROBLEMS: _____

_____

My signature indicates that:

I am supportive of a referral to Hands TheFamilyHelpNetwork.ca.
The above written reason for referral is accurate and has been explained to me.
I give permission for this information to be shared with Hands TheFamilyHelpNetwork.ca.
I understand that Hands TheFamilyHelpNetwork.ca will create a paper and electronic file. Hands TheFamilyHelpNetwork.ca may contact me in the future for research and evaluation purposes or to share agency related information.
I understand that Hands TheFamilyHelpNetwork.ca will contact me directly or through the referent to arrange an intake interview and that the initial service plan may be shared with the referent.

Parent / Guardian Signature: _____

Client Signature (12 years or older MUST sign): _____

Referral Source Signature: _____Date: _____

OR

For Health Information Custodians within Circle of Care ONLY (e.g. physicians, OKP)

In lieu of written signature from parent/guardian/client, please check the following

☐ The client is aware of and supportive of the referral to Hands The Family HelpNetwork.ca and understands that HANDS will initiate contact to schedule an intake and create a file. Hands TheFamilyHelpNetwork.ca may contact the client/family in the future for research and evaluation purposes or to share agency related information. PHIPA has been explained to the client.

Referral Source Signature:_____ Date:_____