reconnect
community health services

CENTRAL WEST CONCURRENT DISORDERS
SPECIALIZED SUPPORT SERVICES REFERRAL FORM

Date: _____ Health Card #: _____

First Name: _____ Last Name: _____

DOB (mm/dd/yyyy) _____ Phone #: _____

Street Address: _____

Unit #: _____ City: _____

Province: _____ Postal Code: _____

Gender: ◯ Male ◯ Female ◯ Other

If Other, please describe: _____

Resident Type: ◯ Owned/Rent ◯ Subsidized ◯ Shelter ◯ Homeless ◯ Unknown ◯ Other

If Other, please describe: _____

Living Arrangement: ◯ Self ◯ Parents ◯ Children ◯ Spouse/Partner ◯ Non-Relatives ◯ Unknown ◯ Other

If Other, please describe: _____

Support Type: ◯ Independent ◯ Assisted/Supported ◯ Supervised ◯ Unknown ◯ Other

If Other, please describe:

Mental health concern? ◯ Yes ◯ No

If yes, what is your diagnosis

Do you have substance use issues? ◯ Yes ◯ No

If yes, describe:

Source of Income ◯ ODSP ◯ OW ◯ Pension ◯ Family ◯ Employment ◯ Unknown ◯ Other

If Other, please describe:

Employment Type: ◯ No Employment ◯ Independent/Competitive ◯ Unknown ◯ Other

If Other, please describe:

Education Level: ◯ University ◯ College ◯ High School ◯ Elementary ◯ Other

If Other, please describe:

Legal Status ◯ No Problems ◯ On Probation ◯ On Parole ◯ On Bail ◯ Other

If Other, please describe:

Referral Source

Name:

Position:

Organization:

Phone #:

Please send completed referral forms to:
Reconnect Community Health Services
1281 St Clair Ave. W
Toronto, ON M6E 1B8
Tel: 416-248-2050
Fax: 416-248-6557