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COPA PROGRAM REFERRAL FORM

Referral Date:

Form completed by:
Client ☐
Caretaker/family ☐
Service Provider ☐

Individuals must be:

- **55+ years living with Addictions**
- **Living within the Toronto Central LHIN boundaries (Priority given to individuals living west of Yonge St. to Kipling Ave.,north to Eglinton Ave. & south to Lakeshore Blvd.)**

CLIENT INFORMATION

First Name:	Last Name:	
Health Card #: Version Code:	Do you speak English? Preferred Language: Do you have access to an Interpreter? Yes ☐ No ☐	
Age: DOB: _____/_____/_____ mm / dd / yyyy	Phone #: Is it okay to leave a message? Y / N	Street Address: Unit #:
Ethnicity/culture:	City: Province:	Postal Code:

Male ☐ Female ☐ Trans: ☐ Other: _____

REFERRAL SOURCE INFORMATION

Name:_____ Title:_____

Organization:_____ Phone #: _____

Fax #:_____ Email:_____

Relationship to client: _____

Reason for referral: _____

_____

Client's thoughts/concerns about their substance use: _____

_____

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

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REFERRAL SOURCE INFORMATION (continued)

A. **Does the client have**:	(circle one for each question)		
Power of Attorney for Personal Health Care?	Yes	No	Unknown
Power of Attorney for Finances?	Yes	No	Unknown
Substitute Decision Maker for Finances and Personal Health Care?	Yes	No	Unknown

B. Has the client agreed to apply for service? Yes ☐ No ☐

C. Do you intend to remain involved with the client if they are accepted for this service?
Yes ☐ No ☐

PHYSICAL HEALTH

Do you have any health conditions/chronic illnesses and/or physical disabilities?
Please describe all: _____

_____

_____

_____

Are you currently on any medications? Yes ☐ No ☐ Unknown ☐
If yes, Prescribed meds ☐ Over the counter meds ☐ (Please attach list of medications if possible)

Please describe: _____

_____

_____

_____

Mobility issues: Yes ☐ No ☐ Vision issues: Yes ☐ No ☐ Hearing issues: Yes ☐ No ☐

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SUBSTANCE USE/GAMBLING

Do you have substance use concerns? Yes ☐ No ☐ Unknown ☐ Unsure ☐

Have you been diagnosed with substance use disorder? Yes ☐ No ☐ Unknown ☐

Please describe: _____

_____

_____

Do you have gambling concerns? Yes ☐ No ☐ Unknown ☐ Unsure ☐

Please describe: _____

_____

_____

Please list all substances:

Substance:_____Frequency: daily ☐ weekly ☐ monthly ☐ occasional ☐
Last time used:_____average amount _____

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Last time used:_____average amount _____

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MENTAL HEALTH

Do you have concerns about your mental health? Yes ☐ No ☐ Unknown ☐ Unsure ☐
Please describe: _____

_____

_____

Have you been diagnosed with mental illness? Yes ☐ No ☐ Unknown ☐
Please describe: _____

_____

_____

Are you currently on any medication for your mental health? Yes ☐ No ☐ Unknown ☐
Please describe: _____

_____

_____

Do you have any immediate safety concerns for your mental health/wellbeing (including self-harm/suicidality)? Yes ☐ No ☐
Please describe: _____

_____

_____

Do you have any memory problems/cognitive impairments? None ☐ Suspected ☐ Diagnosed ☐

Please describe: _____

_____

_____

_____

_____

HOSPITALIZATIONS:

Have you visited the Emergency Department or have been hospitalized within the last two years due to mental health/physical health/ substance use?

Yes ☐ No ☐ Unknown ☐

# of Emergency Department visits in the past 2 years: _____

# of Emergency Department visits in the past 6 months: _____

Date of last hospitalization_____Reason: _____

_____

_____

CURRENT SUPPORTS

Please list all current treatment providers (GP, psychiatrist, etc.) and community supports (family, support workers, etc.) who are working with you right now:

Name	Role/Relationship	Organization	Client consent to contact Y/N	Phone #

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CURRENT LIVING SITUATION (COPA does not provide housing or conduct housing searches)

HOUSING: currently housed ☐ homeless ☐

What type of housing do you presently live in? Market Rent ☐ Subsidized ☐
Room/boarding home ☐ Shelter ☐ Long Term Care ☐ Correctional Facility ☐ Other:
_____

Housing Support type: Independent ☐ Assisted/Supported ☐ Supervised ☐

Living Arrangement: Living alone ☐ Living with spouse/partner ☐
Living with non-relative ☐ Living with Relative(s) ☐ Living with children ☐

INCOME/ EMPLOYMENT:

What is your primary source of income? OW ☐ ODSP ☐ CPP ☐ OAS ☐
Private Pension ☐ Other: _____

Are you currently employed? Yes☐ No ☐
Please describe_____

EDUCATION:

What is your highest level of education? _____

Are you currently in school? Yes ☐ No ☐

LEGAL:

Are you currently involved in the criminal justice system? Yes ☐ No ☐ Unknown ☐
If yes, please describe: _____

_____