

**The Service Coordination Project for  
Homeless People Living with HIV/AIDS  
Referral Form**

Client Full Name \_\_\_\_\_ D.O.B. dd/mm/yyyy

Current Housing Situation \_\_\_\_\_

Address (or mailing address) \_\_\_\_\_

Patient's cell phone/contact number (if any) \_\_\_\_\_

Name of partner/friend \_\_\_\_\_ Relationship \_\_\_\_\_

Partner/friend's phone number(s) \_\_\_\_\_

OHIP \_\_\_\_\_ VC \_\_\_\_\_ SIN \_\_\_\_\_

Gender: Female ( ), Male ( ), Trans Female ( ), Trans Male ( )

Source of Income \_\_\_\_\_

ODSP  \_\_\_\_\_ OW  CPP  Private Disability

Client is  Canadian Citizen,  Landed Immigrant,  Refugee/Protected Person  
or  Refugee Claimant.

**Referring Agency** \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact# \_\_\_\_\_

Referral Reason \_\_\_\_\_

\_\_\_\_\_

If the Referral source is a Hospital please attach the Discharge Paperwork.

**Health**

Immediate Health Concerns \_\_\_\_\_

\_\_\_\_\_

Health Conditions (HIV/AIDS, Hepatitis, Diabetes, TB, Etc) \_\_\_\_\_

\_\_\_\_\_

**Last TB testing** date: \_\_\_\_\_ Results: \_\_\_\_\_

**Hospitalizations** in the last six months

Hospital Name \_\_\_\_\_ length \_\_\_\_\_

Reason \_\_\_\_\_

Hospital Name \_\_\_\_\_ length \_\_\_\_\_

Reason \_\_\_\_\_

**Family Dr's Name** \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

**Specialist Name** \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Spec. Area \_\_\_\_\_

**Specialist Name** \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Spec. Area \_\_\_\_\_

**Medication Regimen (1 HAART. 2 Mental Health Meds. 3 Others)**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Drug allergies** (if any) \_\_\_\_\_

**Primary Pharmacy Name** \_\_\_\_\_ Address \_\_\_\_\_

**Mental Health Diagnosis** \_\_\_\_\_

Currently on treatment: Yes \_\_\_\_\_, No \_\_\_\_\_. If yes where \_\_\_\_\_

**Substance/Alcohol Use** \_\_\_\_\_

Currently in treatment: Yes \_\_\_\_\_, No \_\_\_\_\_. If yes where \_\_\_\_\_

Substance/ Alcohol Use Frequency \_\_\_\_\_

**Legal Involvement:** Yes \_\_\_\_\_ No \_\_\_\_\_ (Comment if yes) \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

**Next of Kin** \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Referral Agent Printed Name

\_\_\_\_\_  
Referral Agent Signature

Date (dd/mm/yyyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_