



# Tel-Check Client Referral Form

**PLEASE FAX REFERRAL TO: 519-336-8517**

**OR FOR INQUIRIES CALL 519-336-0120 EXT. 251 TO LEAVE A MESSAGE**

## Client Contact Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone #: Res. \_\_\_\_\_ Cell # \_\_\_\_\_ (circle preferred number)

Address: \_\_\_\_\_

Has consent been provided by client? Yes \_\_\_\_\_ No \_\_\_\_\_

Initial contact should be made with: Client \_\_\_\_\_ Other \_\_\_\_\_

Contact Information and Relationship to client: \_\_\_\_\_

			<b>Economic Status (Circle)</b>	<b>Marital Status (Circle)</b>
Living Alone: If No, How many live in home	Yes	No	Employed	Single
Safety Check:	Yes	No	Ontario Works/SA/ODSP	Married/Partnered
Friendly Phone Visit:	Yes	No	Pension	Separated/Divorced
Health Check:	Yes	No	Unemployed	Other

<b>Does client have current medical symptoms of concern? Yes No (Circle)</b>
<b>Details:</b>
<b>Special Instructions when communicating with client:</b>

Referral Source: Agency: \_\_\_\_\_ Name: \_\_\_\_\_

Contact # \_\_\_\_\_ Date of Referral: \_\_\_\_\_