

# Referral Form



Social Work Community Clinic  
5595 Fenwick Street, Suite 100  
Halifax, NS

Date: \_\_\_\_\_

Referral Source	Client Information
Organization: _____	Name: _____
Name: _____	Contact Information: _____
Contact Information: _____	Can we leave a voicemail: Yes / No
	HRM location: _____

## Reason for referral – Check all that apply

<input type="checkbox"/> Form Filling: Specify _____	<input type="checkbox"/> Supportive Counselling
<input type="checkbox"/> Income Supports: Specify _____	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Eviction Prevention / Housing Support: Specify (Please note we cannot do housing searches) _____	<input type="checkbox"/> Recreation Therapy
<input type="checkbox"/> System Navigation: Specify _____	<input type="checkbox"/> Pharmacological Supports
<input type="checkbox"/> Food Security	

What areas have already been worked on?

Where else have you referred?

Has this referral been discussed with the client? Yes / No