



**STREET HAVEN ADDICTION  
SERVICES OUTREACH  
REFERRAL FORM**

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

Referring Agency: \_\_\_\_\_ Name of staff: \_\_\_\_\_

Agency Contact #: \_\_\_\_\_

Client Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth (dd/mm/yy): \_\_\_\_\_ Client Phone #: \_\_\_\_\_

Alternate contact #: \_\_\_\_\_ Safe to leave a message or text? YES/ NO

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

Client Email Address: \_\_\_\_\_

What is your current access to resources for virtual support?

Wifi    Computer/Laptop    Cell Phone    Tablet    Other \_\_\_\_\_

Presenting concerns:

- Substance use:
- Mental health:
- Income:
- Legal issues:
- Relapse prevention:
- Safety issues:
- Thoughts of suicide:
- Relationships:
- Housing

The reason for completing this referral has been explained to me? YES / NO

Do you currently have other supports? Family/friends/workers/doctor \_\_\_\_\_

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