STREET HAVEN ADDICTION SERVICES
REFERRAL FORM
Please print

Date: _____ Requested Service: Addiction Case Management / Grant House

Referring agency: _____ Name of staff: _____

Phone # of agency: _____ Agency admission date: _____

Name of Client: _____ Preferred name: _____

Date of Birth (dd/mm/yyyy) _____ Age (approx.): _____

Phone # _____ Safe to leave message/text? YES / NO

Address/General Area: _____

Reason for referral _____

- ☐ Substance use: _____
- ☐ Mental health: _____
- ☐ Physical Health: _____
- ☐ Any Income: _____
- ☐ Legal issues: _____
- ☐ Relapse Prevention: _____
- ☐ Relationships: _____
- ☐ Safety issues: _____
- ☐ Have you isolated yourself? _____
- ☐ Thoughts of suicide: _____

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

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

_____

_____

Notes (Other important information):

_____

How did you hear about us? _____

Please fax to **416-916-1059** or email to **GHFAX@streethaven.com**
Attention: Program Supervisor. Thank you.
If you require further information, please call Program Supervisor at
416-960-9430 Ext. 329