Referral Form for The Friends Programs/Services

Thank you for accessing our Services Request Form.
Please note that The Friend programs and services are provincially funded through the Ontario Ministry of Health. Please ensure you have a valid Ontario Health Card. Please note that some of our programs have limited availability and may have a waitlist.

We encourage you to complete this form so our team can understand your needs and connect you with the most appropriate support. If services are not immediately available, we will do our best to guide you to alternative options and keep you informed as space becomes available.

Referrals can be emailed to referrals@thefriends.on.ca or faxed to: 705.746.8139

Date of referral: _____

Referral source (please check off as appropriate):

- ☐ Self
- ☐ Family
- ☐ Physician
- ☐ TCC/Discharge Planner
- ☐ Ontario Health atHome
- ☐ GEM Nurse
- ☐ Internal
- ☐ HAL
- ☐ PATH
- ☐ Other _____

Client Name: _____Date of Birth: _____

Health Card Number: _____Version Code: _____ Diagnosis: _____

Address: _____ City/Town _____ Postal Code: _____

Telephone: _____ Work:_____Cell: _____

Email address:_____

Contact Person/Caregiver: _____ (if different from Client name)

Telephone: _____ Work:_____Cell: _____

Care Coordinator: _____

Referral Form for The Friends Programs/Services

Programs Requested

- ☐ Accessible Housing (24 Hour Attendant Care)
- ☐ Assisted Living for Seniors
- ☐ Senior's Homemaking
- ☐ Outreach (Attendant Care)
- ☐ Post Stroke (Transitional Care)
- ☐ Transitional Respite Program
- ☐ Alzheimer Overnight Respite Program
- ☐ In-Home Caregiver Respite
- ☐ Caregiver Support Program
- ☐ Adult Day Program
- ☐ Other

Description of services requested: (for example; assistance with personal hygiene, meal preparation, medications, light housekeeping, social interaction, supervision, education, in home caregiver relief)

_____

_____

_____

_____

Other agency/service providers (private/government/other): _____

I, _____, give my consent and am willing to release information and share assessment data between the referral source noted above and the Friends.

_____

SignatureofClient/SubstituteDecisionMaker/PowerofAttorney

FOR OFFICE USE ONLY

Referral Received by: _____ Entered:_____

Referral Directed to: _____ Date: _____

We respect your privacy. The information you provide will be used solely to assess, coordinate, and deliver requested care services. We do not sell, rent, or share your personal information with third parties for marketing or unrelated purposes. Your data is handled securely and only accessed by authorized personnel.