COMMUNITY CONNECTION CENTRE - OLDS
Connecting People, Building Community

CLIENT REFERRAL FORM

CLIENT INFORMATION AND CONSENT

The personal information collected through this form is for the purpose of supporting client wellbeing through assessment, referral, service coordination, and program planning. This collection is authorized by Section 4(c) of the Protection of Privacy Act. For questions about the collection of personal information, please contact the Town of Olds ATI Coordinator at ATIRequests@olds.ca.

CLIENT INFORMATION

Name:

Phone Number: Cellphone Number:

Date of Birth: / / Gender: ☐ Male ☐ Female ☐ Other

Home Address:

REASON FOR REFERRAL (CHOOSE ALL THAT APPLY):

☐ Navigation of Community Supports & Services
☐ Financial Supports / Benefits Assistance
☐ Meal Assistance / Food Security
☐ Grocery Shopping
☐ Assisted Transportation
☐ Socialization
☐ Housing
☐ Legal Assistance
☐ Snow Shoveling / Yard Maintenance
☐ Recreation / Leisure
☐ Other: _____

Additional Comments (If applicable):

_____

REFERRER'S INFORMATION

Referral Source (check one):

☐ Home Care / Home Living ☐ Family Doctor ☐ Hospital ☐ Primary Care Network ☐ Clinic / Agency ☐ Other:

Referrer Name: Organization/Clinic/Agency:

Phone Number: Fax:

Email: Date of Referral:

☐ Consent to disclose relevant personal/health information has been obtained prior to submission.
☐ Client is aware of and agrees with this referral.

COLLATERAL CONTACTS:

Healthcare Provider Information (If Applicable):

- Does the client have a primary healthcare provider? ☐ Yes ☐ No ☐ Unsure
- Provider Name: _____ Phone: _____ Fax: _____
- Home Care Case Manager (if applicable):
  - Name: _____ Phone: _____ Fax: _____ Email: _____

Caregiver Information (If Applicable):

- ☐ Client has caregiver support ☐ Client is a caregiver ☐ Insufficient caregiver support
- Caregiver Name: _____ Relationship: _____
- Phone: _____ Email: _____
- Additional Caregiver (if applicable):
  - Name: _____ Relationship: _____
  - Phone: _____ Email: _____

Emergency Contact:

- Name: _____ Relationship: _____Phone: _____

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LIVING & BACKGROUND INFORMATION:

Living Arrangements (check all that apply):
□ Alone □ With Spouse / Partner □ With Family □ With Roommates
□ Housing Instability / Experiencing Homelessness □ Other: _____
Marital Status:
□ Married / Common Law □ Separated □ Divorced □ Widowed □ Single (never married)
Primary Source of Income (if known): _____
Does the client have access to reliable and affordable transportation?
□ Yes □ No □ Unsure Main mode of transportation: _____
Are there any identified risks for staff completing home visits?
□ Yes □ No □ Unsure If yes, please describe: _____

EQUITY & CULTURAL INFORMATION:

□ First Nations / Métis / Inuit
□ Member of a Visible Minority (Non-Indigenous)
□ Person with Disabilities
□ Other: _____
Ethnocultural Community / Country of Origin: _____
Year Arrived in Canada (if applicable): _____

REFERRER'S INFORMATION

□ Cognitive or Memory Challenges
□ Mental Health Issues
□ Physical Mobility Challenges
□ Hearing Impairment
□ Visual Impairment
□ Clutter / Hoarding
□ Elder Abuse Concerns
□ Health Challenges / Barriers
□ Caregiver Concerns
□ Isolation
□ Grief and Loss
□ Diverse Cultural Needs
□ Literacy Support
□ Other:_____

SPECIAL & ADDITIONAL CONSIDERATIONS (CHECK ALL THAT APPLY)

□ Cognitive or Memory Challenges
□ Mental Health Issues
□ Physical Mobility Challenges
□ Hearing Impairment
□ Visual Impairment
□ Clutter / Hoarding
□ Elder Abuse Concerns
□ Health Challenges / Barriers
□ Caregiver Concerns
□ Isolation
□ Grief and Loss
□ Diverse Cultural Needs
□ Literacy Support
□ Other: _____

CONSENT & AGREEMENT

By signing or providing verbal consent, the client confirms they understand the purpose of the referral, the information that may be shared, and the services that may be provided.

Is the individual aware of the referral? □ Yes □ No
Has verbal consent been given to share information and proceed with services? □ Yes □ No

Client Signature: _____ Date: _____

Please email completed referral form to **sdewald@olds.ca**. Please note that referrals will be reviewed and place in order of highest need.