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# *EXTERNAL REFERRAL FORM - TRANSITIONAL CONNECTOR SERVICES*

| **Client Information** | **Agencies Involved** |
|---|---|
| Name:<br><br>Gender:<br><br>Date of birth:<br><br>Address:<br><br>Contact Number:<br>Alternate Number:<br>Preference for Text ☐ Yes ☐ No<br>Can a detailed message be left? ☐ Yes ☐ No<br>Any Communication barrier? ☐ Yes ☐ No<br>Please Specify:<br><br>Email Address: | *Is client currently/historically involved with any other agencies/community support services?*<br><br>**Agency** — **Historically** — **Currently**<br><br>Children's Mental Health ☐ ☐<br>Mental Health Services ☐ ☐<br>Addictions Services ☐ ☐<br>Crisis Intervention Centre ☐ ☐<br>_____<br>_____<br><br>Comments: |
| **Referral Agent Information** | **Services/Supports Needed** |
| Date of Referral to T/C Services:<br><br>Agency/Source:<br><br>Phone/Fax:<br><br>Consent to share information ☐ Yes ☐ No<br>***Please attach signed consents if applicable**<br><br>Relevant assessments attached ☐ Yes ☐ No | *What services/supports do you believe the client needs help accessing/connecting to?*<br><br>☐ Education ☐ Employment<br>☐ Mental Health ☐ Housing<br>☐ Recreation ☐ Addictions<br>☐ Health _____ |
| **Reasons for Referral for Transition Connector Services** (relevant past history, mental health needs, treatment planning, etc) **:** | |
| **Signature:** (of referral source) | **Date:** |