



CASEY HOUSE OUTPATIENT REFERRAL FORM

Casey House – a small specialty hospital providing ground-breaking care for people living with and at risk of HIV offering inpatient and outpatient services

A goal-focused outpatient program running Mon-Fri, supporting clients with complex health needs to build their resilience towards wellness and health outcomes. These services consist of one-on-one care and group sessions from an interdisciplinary clinical team.

Interdisciplinary clinical services include:

1. Nursing
2. Psychiatry/mental health clinicians
3. Allied health services
4. Harm reduction services

Please complete all sections of the form before submission. Fax completed referral forms to [416-324-5109](tel:416-324-5109).

REFERRAL DATE:
REFERRAL CRITERIA:
1. 18 years or older 2. HIV+ or part of a community at higher risk of HIV which includes people who (please select all that apply): <input type="checkbox"/> Black, Indigenous and other racialized populations <input type="checkbox"/> Newcomers and refugees to Canada <input type="checkbox"/> Trans people/ 2SLGBTIQ+ <input type="checkbox"/> experiencing poverty <input type="checkbox"/> have been incarcerated <input type="checkbox"/> are experiencing negative impacts of substance use <input type="checkbox"/> experiencing homelessness or don't have stable housing <input type="checkbox"/> with mental health concerns 3. Able to travel to Casey House 4. Able to participate in group/community environment 5. Interest and willingness to engage in programming and set goals Does the client meet the criteria above? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the client aware of this referral*? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*If the client is not aware of the referral please discuss it with them before submitting</small>

REFERRING PERSON:
First Name:
Last Name:
Organization (if applicable):
Relationship to client:
Address:
Phone Number:
Email:

CLIENT INFORMATION:			
First Name:		Last Name:	
Pronouns:	she/her	he/him	they/them
			Not Listed:
Date of Birth (yyyy-mm-dd):			
Health Card Number:		Version Code:	
Address:			
Phone Number*:		Client's Email:	

Please ensure you include contact information for the client, we need to reach out to them to complete our intake process. If the client does not have a contact number please provide details on how we can get in touch with them below

HIV Status: Positive Negative Unknown Client prefers not to answer

Does the client require a translator? No Yes If yes, specify language: _____

Reason for referral/Services required (select all that apply):

Nursing services

- | | | |
|--|--|---|
| <input type="checkbox"/> Psychiatry/Mental Health Services | <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Harm Reduction Services |
| <input type="checkbox"/> Recreational/Art Therapy | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Group Programing & Social Supports |
| | <input type="checkbox"/> Case Management | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Social Work | |
| | <input type="checkbox"/> Peer Support | |

REASON FOR REFERRAL & ADDITIONAL INFORMATION:

Please include recent discharge summaries, progress notes and any other relevant information with referral.

Fax completed referral forms to [416-324-5109](tel:416-324-5109).
 Questions? Please contact referral@caseyhouse.ca