



Circle of Support - Social Prescribing Professional Referral Form

E-mail: info@goldencircle.ca

Fax: 403-343-7977

Client Information:

| | | | |
|---|-------------|---------------------------------------|--------------|
| Name: | | Date of Birth: (dd/mm/yyyy) | |
| Home Phone: | | Cell Phone: | |
| Address: | | | |
| Gender: | Male | Female | Other |
| Living Arrangements (E.g: alone, with spouse/family, other, etc.) | | | |

Reason for Referral (choose all that apply):

| | | | |
|---|--|---|---|
| <input type="checkbox"/> | Financial (E.g.: assistance with applications, accessing subsidy, financial review to ensure benefits are maximized) | | |
| <input type="checkbox"/> | Food Security (E.g.: grocery delivery, frozen meals, meals on wheels, escorted shopping) | | |
| <input type="checkbox"/> | Transportation (E.g.: access to different transportation options, funding options for long distances) | | |
| <input type="checkbox"/> | Home Maintenance (Eg.: Housekeeping, Yard care, Snow removal, Handyman connection) | | |
| <input type="checkbox"/> | Housing (Explore alternate housing options to fit the need of the person) | | |
| <input type="checkbox"/> | Health (E.g.: Homecare connection/referral, medication/equipment coverage, access) | | |
| <input type="checkbox"/> | Mental Health (E.g.: connection to Seniors Mental Health Outreach, connection to counselling/grief supports) | | |
| <input type="checkbox"/> | Social Supports (E.g.: explore community groups, clubs, programs to address social need) | | |
| <input type="checkbox"/> | Other (provide details) | | |
| Is the individual aware of the referral? | | Y | N |
| Has verbal consent been given? | | Y | N |

Referrer's Information:

| | | | |
|----------------|--|-----------------------|--|
| Name: | | Clinic/Agency: | |
| Date: | | Phone: | |
| E-mail: | | Fax: | |