Respiteservices.com Agency Referral Form

Please print clearly/legibly within the spaces provided. All areas must be completed.

Referring Agency:	
Name:	**Phone:**
Position:	**Email:**
Is the family currently connected to a Social Worker / Service Coordinator / Case Manager ◉ **Yes** ○ **No** If yes please list name and contact info: _____	

☐ **I/we, confirm that verbal and/or written consent, has been obtained from the family and/or participant named in this application, to use and/or disclose their personal information to respiteservices.com for the purpose of exploring and/or connecting to respite services in the city of Toronto.**

Date confirmed with family: _____ _____
Signature of referral source

Caregiver Name		
Relationship	☐Mother ☐Father ☐Legal Guardian ☐Other _____	
Languages Spoken	☐English ☐French ☐Other _____	
Address		Postal Code:
Phone	Home:	Cell:
Email		

French language services are available. Family requests service in French: ○ **Yes** ○ **No**

Please note: Translation services are not provided. If family requires service other than English/French, please complete below

Primary Contact		
Relation to Family		
Phone	Home:	Cell:
Email		

Individual Name		
Gender Identity	☐Male ☐Female ☐Identifies As: _____	
DOB (dd/mm/yy)	____/____/____/	☐ Eligibility confirmed by DSO-TR (18 yrs+)
Diagnosis		

Reason for Referral:

☐ Family Orientation ☐ Funding Workshop (ACSD/SSAH)
☐ Camp Options ☐ Respite Options ☐ CHAP worker ☐ Private Charity Respite Funding Options

Relevant information (ex. Funding/programs/services currently being accessed, agencies involved)**:**

_____
_____
_____

Return to:
Mail: 112 Merton Street, Toronto, ON, M4S 2Z8 Fax: 416 481 1512 email: info@respiteservices.com
For any inquiries please contact 416-322-6317 x1

Office Use only Date Rcvd in office: _____ CYSIS:_____ IND ID:_____ scanned ☐
1 _____ 2 _____