

CONNECTIONS PROGRAM

Referral for Nurse Navigator Support

If you would like to complete this form through phone call, please call (416) 462-1010.

Name		Date of Birth:	_____
Pronoun			DD/MM/YYYY
Address or Location: (our catchment area is the Greater Toronto Area – including Toronto, Peel Region, York Region, Durham Region)			
Method of contact			
<input type="checkbox"/> Phone			
Is text okay? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Is voicemails okay? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Email			
Is this a self-referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		Referral Source Name:	
		Relationship to Client:	
		Referral Contact Information:	
How did you hear about Connections?:		Is the client aware of this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No

What is your child welfare status? (Extended Society Care was formerly named crown ward).

Extended Society Care (<18) Former Extended Society Care (18 – 29) CCYS (18 – 21)

What type of service are you (the client) looking for?

System Navigation Supports

What type of services are you looking for?

- Psychiatric/Mental Health Assessment
- Addictions
- Primary Care
- Disability Support Services (i.e. ODSP, DSO)
- Educational Assessment
- Psychotherapy
- Case Management

Please fill this out if you are looking for a psychotherapy/counselling

Have you received an assessment for therapy in the last two years? (I.e. a health care provider who has indicated there is a need for psychotherapy, and also what type of therapy) Yes No

Are you currently seeing a therapist? Yes No

Would you like to continue to see this therapist? Yes No

If yes: Name of Therapist:

Phone # of Therapist:

Do you have access to a regular health care provider (i.e. family doctor or a nurse practitioner)? Yes No