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

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Please complete all sections of the form before submission. Fax completed referral forms to 416-907-7186.

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 al that apply):** ☐ Black, Indigenous and other racialized populations ☐ Newcomers and refugees to Canada ☐ Trans people/ 2SLGBTIQ+ ☐ experiencing poverty ☐ have been incarcerated ☐ are experiencing negative impacts of substance use ☐ experiencing homelessness or don't have stable housing ☐ 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? ☐ Yes ☐ No Is the client aware of this referral*? ☐ Yes ☐ No *If the client is not aware of the referral please discuss it with them before submitting

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

☐ **Psychiatry/Mental Health Services**
☐ **Recreational/Art Therapy**
☐ **Physiotherapy**
☐ **Massage Therapy**
☐ **Case Management**
☐ **Social Work**
☐ **Peer Support**
☐ **Harm Reduction Services**
☐ **Group Programing & Social Supports**
☐ **Other:**

REASON FOR REFERRAL & ADDITIONAL INFORMATION:

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

Fax completed referral forms to 416-907-7186.
Questions? Please contact referral@caseyhouse.ca