GAPPS REFERRAL FORM

Getting Appropriate Personal & Professional Supports

Client Name: ______________________ **Referral Date:** ______________________

Date of Birth: ______________________ **Gender:** **Male** ☐ **Female** ☐ **Transgender** ☐

Address: ______________________ **Primary Care Provider:** ______________________

______________________ **Health Card No.:** ______________________

Phone: ______________________ **Is the client aware of the referral? Yes** ☐ **No** ☐

WHO TO REFER?

An individual with a complex mental health or addictions issue who is currently **NOT ACCESSING / RECEIVING ANY SERVICES.**

Services used in the PAST YEAR		
	☐ Physical Health Services *(List)*: _____	☐ Hospitalization *(List)*: _____
	☐ Mental Health Services *(List)*: _____	☐ Emergency Department Services
	☐ Addictions/Withdrawal Services *(List)*: _____	☐ Social Services *(List)*: _____
	☐ Crisis Services *(List)*: _____	☐ Shelters *(List)*: _____
	☐ Case Management Services *(List)*: _____	☐ Housing Assistance Services *(List)*: _____
		☐ Other *(List)*: _____

CLIENT IDENTIFIED CONCERNS:

MENTAL HEALTH	***SUBSTANCE ABUSE***	***PSYCHOSOCIAL***	***MEDICAL/PHYSICAL***
☐ Mood Problems	☐ Alcohol	☐ Unemployment	☐ Chronic Pain
☐ Anxiety Problems	☐ Drugs	☐ Financial Issues	☐ Medication Issues
☐ Psychosis	☐ Polysubstances	☐ Legal Issues	☐ Medical/Physical/Cognitive Illness/Disability *(List)*: _____
☐ Personality Problems	☐ Gambling	☐ Housing	
☐ Other _____	☐ Other _____	☐ Other _____	

How can GAPPS assist?	***REFERRAL SOURCE:*** Name of Facility/Program/Agency/Clinic
	(Please Print Name & Phone Number)

Please fax/mail or if you have any questions or concerns:

GAPPS Program Coordinator

710 Victoria Ave E, Thunder Bay, ON P7C 5P7

TEL: 624-3412 • FAX: 624-3575 or 624-3401

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