

OUTREACH SERVICES

BETTER AT HOME

Phone # 604-530-3020 Fax # 604-532-1320

Agency Referral Form:

CLIENT NAME: _____

ADDRESS: _____

PHONE: _____

****Does this person have or have they been exposed to an infectious condition?**

Yes _____ No _____

****(Please note: the above question must be answered before we can proceed)**

REFERRED FOR **OUTREACH** PROGRAMS

- | | |
|--|--|
| <input type="checkbox"/> Telephone Buddy | <input type="checkbox"/> Information & Referral |
| <input type="checkbox"/> Home Visit by staff | <input type="checkbox"/> Sharing & Caring Social |
| <input type="checkbox"/> Government Programs Counselor | <input type="checkbox"/> Housing Counselor |
| <input type="checkbox"/> Coffee & Connecting Support Group | |

REFERRED FOR **BETTER AT HOME** SERVICES

- | | |
|--|---|
| <input type="checkbox"/> Transportation Assistance | <input type="checkbox"/> Grocery Shopping |
| <input type="checkbox"/> Light Housekeeping | <input type="checkbox"/> Friendly Visitor |

NOTES:

REFERRED BY: _____

DATE: _____ CONTACT # _____

Has the client given permission for us to contact them? _____