

Toronto Aboriginal Care Team



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**REFERRAL FORM**

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This form is for administrative referral purposes only. No personal or confidential information regarding reasons for referral should be included on this form. The form may be sent by or fax to:

Fax (attention to Care Team intake): (416) 928-0706

**Referral Source:**

Name:

Agency (if applicable):

Address:

Phone:

**Agency making referrals please include a two-way signed Consent to Release Information form.**

**Client Information:**

Name:

Address:

Phone:

**Alternative Contact:**

If no client address or phone number is available, who can be contacted regarding this client?

Name:

Agency/Relationship to client:

Phone:

**Appointment Date and Time: \* For TACT use only**

Date:

Time:

Location:

Toronto Aboriginal Care Team Case Manager assigned:

Additional information:

Clients are reminded of their responsibility to keep appointments. If a cancellation is necessary, please contact the Toronto Aboriginal Care Team at (647) 258-0336. Thank you.

\_\_\_\_\_  
Referring Worker Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
TACT Supervisor Signature

\_\_\_\_\_  
Date