CLIENT INTERAGENCY
REFERRAL FORM

SOCFH.
SPECTRUM OF CARE FOR HOMELESSNESS

This form is designed for use by SOCFH member organizations and partner agencies to facilitate client referrals between services. Please ensure all information is complete and accurate. Confidentiality and respect for the client's preferences and needs are of utmost importance.

Referral Information

- Date of Referral: _____
- Referring Organization: _____
- Referring Staff Member: _____
- Contact Information of Referring Staff:
  - Phone Number: _____
  - Email Address: _____
- Receiving Organization: _____
- Receiving Staff Contact Name (if known): _____

Client Information

- Client Full Name: _____
- Preferred Name: _____
- Pronouns: (e.g., He/Him, She/Her, They/Them) _____
- Date of Birth: _____
- Contact Information:
  - Phone Number: _____
  - Email Address: _____
  - Preferred Method of Contact:
    - Phone
    - Email
    - Other (specify): _____

Demographic Information

(for inclusive service and accommodation needs)

- Gender Identity: _____
- Sexual Orientation: _____
- Primary Language: _____
- Ethnicity/Race: _____
- Nationality: _____

CLIENT INTERAGENCY
REFERRAL FORM

SOCFH.
SPECTRUM OF CARE FOR HOMELESSNESS

Reason for Referral

1. Primary Reason for Referral:
    - Housing Assistance
    - Mental Health Support
    - Employment or Vocational Assistance
    - Legal Support
    - Substance Use Support
    - Medical Services
    - Safety and Crisis Intervention
    - Other (please specify): _____
    -
2. Brief Description of Client's Current Situation and Support Needs:

3. Specific Services Requested from Receiving Organization:

4. Has the client expressed any specific needs or accommodations for their comfort and safety?
    - Yes
    - No
    - If yes, please describe: _____

CLIENT INTERAGENCY
REFERRAL FORM

SOCFH.
SPECTRUM OF CARE FOR HOMELESSNESS

Background and Relevant History

1. Current Living Situation:
    - Street
    - Shelter
    - Temporary Accommodation
    - Other (please specify): _____
2. Relevant Medical or Mental Health Information: (If applicable, e.g., medications, support needs)

3. Additional Information that May Support Service Provision: (e.g., safety concerns, disability accommodations, other agencies involved)

Client Consent

- Has the client consented to this referral and the sharing of their information with the receiving organization?
    - Yes
    - No
- Client Signature (or Verbal Consent Recorded):
    - Signature (if applicable): _____
    - Date: _____

Referring Staff Notes and Follow-Up

- Does the referring organization request a follow-up or status update from the receiving organization?
    - Yes
    - No
- Additional Notes:

For Receiving Organization Only

- Date Referral Received: _____
- Staff Contact Assigned: _____
- Follow-Up Action Taken: _____

This form ensures that key details are communicated clearly between organizations, supporting continuity of care and respecting the client's needs and consent.