Stonehenge
Therapeutic Community

Support. Hope. Thrive.

PROTECTED B WHEN COMPLETED

TRANSITIONAL HOUSING COMMUNITY PARTNER REFERRAL FORM

CLIENT LEGAL NAME (as it appears on health card):	**CHOSEN NAME** (if applicable):
DATE OF BIRTH:	**PRONOUNS:**
PRIMARY CONTACT INFORMATION Phone: Email:	**REFERRAL TO:** ☐ Female identifying transition house ☐ Male identifying transition house

BEST WAY TO REACH CLIENT: *(if providing staff contact, please provide updated contact information upon leaving treatment)*

☐ phone ☐ email ☐ other (please specify):

Can we leave a voicemail:

☐ Yes ☐ No

CONTACT INFORMATION OF REFERRING WORKER:

Name:

Phone: Email:

Has consent been provided for referring worker to support contacting the client, if the client has left treatment? ☐ Yes ☐ No

COMMUNITY SERVICE PROVIDER INVOLVEMENT

List all providers involved and their role:

1.

2.

3.

Is this client interested in abstinence based Transitional Housing and the requirements of meeting regularly with support staff? *(mandatory)*	☐ Yes ☐ No ☐ Unknown

CURRENT HOUSING SITUATION: ☐ Unhoused ☐ Precariously Housed ☐ Housed ☐ Incarcerated ☐ In Treatment (*provide expected discharge date*)	Please describe:

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PROBATION AND PAROLE INVOLVEMENT: ☐ Yes ☐ No

If yes, please describe:

SUBSTANCE USE TREATMENT HISTORY: *Must have completed a bed-based treatment program within the last 12 months.*

Please describe:

FUNDING/INCOME SOURCE:

☐ None ☐ Employment

☐ OW ☐ ODSP

☐ Other:

SAMH USE ONLY: SCREENING OUTCOME

☐ Eligible

☐ Ineligible

Please specify:

PLEASE FAX COMPLETED FORM TO SAMH HOUSING AT: 519-837-8035