



ERC Program Referral Form

Please complete the highlighted sections of this form and email it to intaketperc@turningpointrecovery.com
If you are unsure how to answer a question, just provide any information you have or type NA.

The ERC is located at 7660 Minoru Gate. Drop-offs and walk-ins are not permitted. All intakes must be scheduled in advance.

Part I – Client Information

Client Name: _____ Alias/preferred name (if applicable): _____

Referral Date: _____ Gender Identity: _____

Date of Birth : _____ PHN (if known and disclosed): _____

As of today, is the client staying?
 Home that I own Home that I rent Homeless Staying with family Staying with friends/others

What is the client's preferred language?
 English French Other: _____

Note: services are provided in English, but we can work to find an interpreter

Part II – Health Information

Has client been tested for COVID-19? (Yes or no) _____

 If YES, is the result positive, negative, or unknown? _____

Has the client been in contact with a known or suspected COVID-19 case? (Yes or no) _____

If YES please provide detail (where/when): _____

Has the client been exhibiting any of the following symptoms?

 New onset of dry cough (Yes or no) _____

 New onset of shortness of breath (Yes or no) _____

 Self-reported fever (Yes or no) _____

 New influenza symptoms and/or vomiting or diarrhea (Yes or no) _____

Does the client have any underlying risk factors? (Y/N or describe) _____

List any prescription or over the counter the client uses: _____

List any recreational drugs the client uses (including alcohol): _____

Does the client have any physical accessibility needs? If so, describe: _____

Part III – Contact

Referring Agency: _____ Name of person making referral: _____

Agency Contact phone: _____ Agency contact email: _____

Client contact phone: _____ Client Contact Email: _____

Any other information you would like to provide: _____