CAYR
COMMUNITY CONNECTIONS
People Supporting People

REFERRAL FOR HIV SUPPORT

Date of referral		
Name of individual	*First:*	*Last:*
Preferred method of contact (telephone/email)		
York Region Municipality	☐ Georgina ☐ East Gwillimbury ☐ Newmarket ☐ Aurora ☐ Markham	☐ Richmond Hill ☐ Whitchurch Stouffville ☐ Vaughan ☐ King
Is individual connected to an HIV specialist?	☐ YES ____ *(List name of specialist)* ☐ NO	
Is this a new diagnosis?	☐ YES ☐ NO	
Most recent viral load testing completed:	☐ within the last 3 months ☐ within the last 6-12 months ☐ +1 year ☐ Unknown/undisclosed	
Is interpretation required?	☐ YES ___________________________________ *(List language)* ☐ NO	
Is the individual or their dependents/family members seeking primary care?	☐ YES ____ (quantity) ☐ NO	

10909 Yonge Street, Suite 203, Richmond Hill, ON L4C 3E3
T: 905-884-0613 F: 905-884-7215
Toll free: 1-800-243-7717
Charitable Registration No.: 890484769RR0001
E: info@cayrcc.org
W: www.cayrcc.org
/cayrcommunityconnections
/cayrcc

Any Additional Relevant Information:

☐ **Self-Referral**

☐ **Community Referral** *(ex: Public Health nurse, community agency)*

- Referring contact's full name:

  ____

- Referral contact #:

  ____

- Email:

  ____

Please ensure that the individual being referred has consented to release their information. Please attach their consent form when available.

Please fax this form to ***905-884-7215; Attn: Monica Meza-Opazo*** *or email to* ***mmezaopazo@cayrcc.org****. If you have any questions, please call 905-884-0613 x208.*

CAYR Internal Use Only

Referral received on:

Referral received by:

First contact attempt on:

Notes: