CAYR COMMUNITY CONNECTIONS
People Supporting People

Harm Reduction | HIV/AIDS | Rainbow Space | Learn | Grow | Partner

REFERRAL FOR HCV (hepatitis C) SUPPORT SERVICES

Date of referral		
Preferred name, Preferred pronouns	*First:*	*Last:*
List preferred method of contact (telephone/email/text)	_____ **Can we leave a message/voicemail stating that this is regarding hep C?** Yes / No	
Preferred time of date to contact?	☐ Morning ☐ Afternoon ☐ Evenings ☐ Anytime	
York Region Municipality	☐ Georgina ☐ East Gwillimbury ☐ Newmarket ☐ Aurora ☐ Markham	☐ Richmond Hill ☐ Whitchurch Stouffville ☐ Vaughan ☐ King ☐ Other _____
Is interpretation required?	☐ YES _____ *(List language)* ☐ NO	

Potential interest in additional CAYR program(s): *select all that apply*

- ☐ HIV Support Services
- ☐ Home HIV self-testing kits
- ☐ PrEP supports
- ☐ Rainbow Space Programming
  - Groups and peer-mentoring for 2SLGBTQ+ community members including youth, older adults, and seniors
- ☐ Harm Reduction Supports
  - overdose prevention training, condoms & lubes, sterile needles and syringes, cookers, straight (crack) pipes, screens, push sticks, bowls, mouthpieces)
- ☐ Food, Hygiene, Basic Needs pantry
- ☐ COVID supports: Masks, sanitizers, Rapid Antigen Tests (self-testing)

17665 Leslie Street, Unit 12, Newmarket, ON L3Y 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, physician, community agency)*
Referring contact's full name: _____

Referral contact #: _____

Email: _____

Fax this completed form to ***905-884-7215; Attn: Hep C Support Services.***
If you have any questions, please call Shanice Harris at 905-715-3691.

CAYR Internal Use Only

Referral received on:
Referral received by:
First contact attempt on:
Notes: