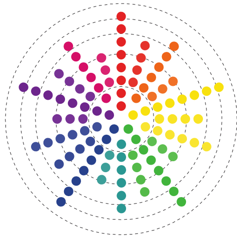

CAYR
COMMUNITY CONNECTIONS
People Supporting People

Harm Reduction

HIV/ AIDS

Rainbow Space

Learn

Grow

Partner

REFERRAL FOR HIV 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	
Is individual connected to an HIV specialist?	☐ Yes ______________________________ *(list name of specialist)* ☐ Not yet	
Is this a new diagnosis?	☐ Yes ☐ No	
Most recent viral load testing completed:	☐ Within the last 3 months ☐ Within the last 6-12 months ☐ More than 1 year ago ☐ Never ☐ Unknown/undisclosed	
Is the individual or their dependants seeking primary care?	☐ Yes ☐ No	

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

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

☐ 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)

☐ Prep Supports

☐ Hep C Support Services

☐ Home HIV self-testing kits

☐ Food pantry, Hygiene or Basic Needs essentials

☐ COVID supports: Masks, sanitizers, Rapid Antigen Tests (self-testing)

Any Additional Relevant Information:

____

____

____

☐ **Self-Referral**

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

Referring contact's full name: ____

Referral contact #: ________________________________

Email: ____

Please ensure that the individual being referred has consented to release their information.

Fax this completed form to ***905-884-7215 or email wali@cayrcc.org; Attn: HIV Support Services.*** *If you have questions, contact Waheeda Ali at 289-383-2624.*

CAYR Internal Use Only

Referral received on:

Referral received by:

First contact attempt on: