Social Prescribing

Referral Form

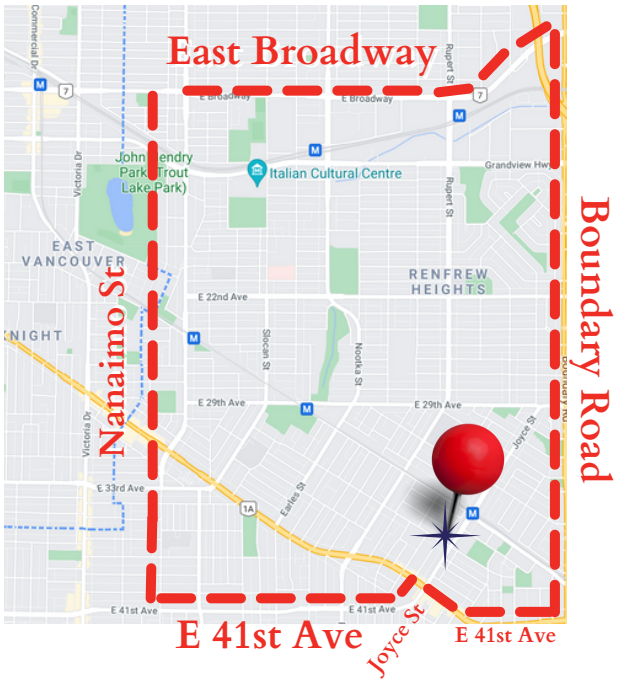
Please Submit this Application Form via Email or In-person

Eda Ertan
Health Link Coordinator
Collingwood Neighbourhood House
www.cnh.bc.ca
5288 Joyce Street Vancouver, BC V5R 6C9

Contact Details:
604-445-1773
eertan@cnh.bc.ca

*Priority Service Area

Applicants from outside of the indicated Priority Service Area are encouraged to submit this form. Submissions will be considered on a case by case basis and possibly referred to other Social Prescribing Sites accordingly.



Collingwood Neighbourhood House

COLLINGWOOD Neighbourhood House

United Way Lower Mainland

Social Prescribing

Referral Form for Social Prescribing Program

Program Information & Eligibility Criteria:

• Social Prescribing (SP) program aims to elevate the quality of life of older adults by enhancing social connectedness and level of physical activity via involvement in community-based programs.

• It is a client driven program as we understand that the client knows what's best for them and as such, our role is to co-create an action plan, empower and support them to achieve their goals.

• We can link older adults to local community programs, culturally appropriate activities and support them to engage in wellness focused activities.

Eligibility Criteria:

- 55 years or older
- Feeling socially isolated or lonely
- Experiencing mental or physical health challenges
- Facing barriers to accessing community resources
- Making frequent trips to primary care or the emergency room

DATE *(Month/Day/Year)*: _____

CONTACT INFORMATION: Who is completing this form?

☐ **Self Referral** Preferred Name: _____

[Healthcare Professional referral confirmation would still required]

☐ **External Referral** Referrer's Full Name: _____

Email: _____ Phone: _____

Relation to Applicant: _____

☐ **Friend or Family** Referrer's Full Name: _____

Email: _____ Phone: _____

Relation to Applicant: _____

HEALTHCARE:

☐ **Agency/Provider** Agency or Department Name *(if applicable)*: _____

Referrer's Full Name: _____

Email: _____ Phone: _____

Referral Form for Social Prescribing Program

CONTACT INFORMATION: About the Applicant

Did the Applicant Consent to this Referral? ☐ YES ☐ NO
(Applicant will NOT be contacted without given consent)

Applicant's Full Name *(or a Preferred Name)*: _____
Applicant's Preferred Pronoun *(He, She, They, etc.)*: _____
Applicant's Date of Birth *(Month/Day/Year)*: _____

Home/Living Address *(Unit#, Street, City, Postal Code)*: _____
_____

Please Choose One of the Following to Indicate the Applicant's Living Situation:
☐ Prefer Not to Say ☐ Live Alone ☐ Live With Others ☐ Stable Housing
☐ Unstable Housing ☐ In a Vehicle ☐ Homeless *(includes shelters and/or couch surfing)*

CONTACT INFORMATION: Applicant's Communication Details

Applicant's Phone Number: _____
Alternative Phone Number: _____
Applicant's Email Address: _____
Preferred Method of Contact *(kindly choose all which applies)*:
☐ Phone Call* ☐ Text ☐ Email ☐ Virtually via Zoom
☐ Letter ☐ In-person *(where?)*:_____

**If 'Phone Call' is Preferred:*
Is it approved/safe to leave a voice message if/when a call is not answered? ☐YES ☐NO

Does the Applicant Require Language Interpretation? ☐ YES ☐ NO
If yes, please indicate the language: _____

Is the Applicant Interested in Requesting Support for Any Other Family Member/s? ☐YES ☐NO
(If so, kindly fill out a separate form for each member)

Primary Care Contact Information:
Name of Family Doctor / Family Nurse Practitioner / Walk-in Clinic: _____
_____