

## YMCA Immigrant Services – Referral Form

Confidential – For Community Partner Use Only

Date of Referral: \_\_\_\_\_

Urgency of Referral:  High (needs immediate assistance)  
 Medium  Low

Referring Organization			
Organization Name:			
Program/Department:			
Contact Name:			
Contact Email:		Contact Phone:	

Client Information			
Client Full Name:			
Client Preferred Name (if any)			
Client Date of Birth (dd/mm/yyyy)		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to say
Address:	HOUSE/FIRE # _____	STREET _____	APT/PO BOX _____ CITY _____ POSTAL CODE _____
Contact:	PHONE _____	CELL _____	EMAIL _____
Preferred Language:	<input type="checkbox"/> English <input type="checkbox"/> French	Other Languages Spoken: _____	
Immigration/Residency Status (check all that apply)	<input type="checkbox"/> Permanent Resident <input type="checkbox"/> Refugee <input type="checkbox"/> Work Permit <input type="checkbox"/> Study Permit <input type="checkbox"/> Citizen <input type="checkbox"/> Other (please specify)		

Services Being Requested (check all that apply)	
Settlement Services	<input type="checkbox"/> Orientation <input type="checkbox"/> Housing <input type="checkbox"/> Employment <input type="checkbox"/> Referrals <input type="checkbox"/> Government Forms <input type="checkbox"/> Translation <input type="checkbox"/> Other (please specify)
Settlement Workers in Schools	<input type="checkbox"/> School Registration <input type="checkbox"/> Daycare/Subsidy <input type="checkbox"/> Camps <input type="checkbox"/> Post-Secondary <input type="checkbox"/> Activities <input type="checkbox"/> Other (please specify)
Language Services	<input type="checkbox"/> Assessment <input type="checkbox"/> LINC <input type="checkbox"/> Conversation Circles <input type="checkbox"/> Literacy/Digital <input type="checkbox"/> Online/ In Person <input type="checkbox"/> Other

Client Needs/Reason for Referral (Please provide brief details to help us better support the client)

Accessibility of Special Considerations	<input type="checkbox"/> Childcare <input type="checkbox"/> Transportation <input type="checkbox"/> Disability <input type="checkbox"/> Mental Health <input type="checkbox"/> Literacy <input type="checkbox"/> Other (please specify)
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