

Olds Seniors 55+

Social Prescribing Referral Form

Full Name: _____	Phone: _____
Address: _____	
DOB: _____	Support Person: _____
Phone: _____	

Reasons for Referral

- ☐ Emotional (Ex: positive coping strategies, to reduce situational/life transition/caregiver stress, or peer psycho-ed groups)
- ☐ Financial (Ex: assistance with applications, financial assessment, arrears/collection concerns and budgeting)
- ☐ Health supports (Ex: medication & or equipment fee coverage, referral & collection to health care professionals)
- ☐ Housing (Ex: seniors Lodging, subsidized or self-contained support housing applications, tours, coordinating moves)
- ☐ In Home supports Coordination (Ex: meals on wheels, housekeeping, Transportation)
- ☐ Resource Navigation (Ex: location, connection to funding, programming, counselling, basic needs- food, clothing, legal support)
- ☐ Social supports/integration (Ex: Community programming, warm hand off to other community professionals)
- ☐ Other: _____
- ☐ Any risks for support workers?

Referring Health Professional: _____	Phone: _____
Email: _____	Date: _____

Referral Forms can be accepted via email at SDewald@olds.ca

The personal information collected through this form is for the purpose of supporting client wellbeing through assessment, referral, service coordination, and program planning. This collection is authorized by Section 4(c) of the Protection of Privacy Act. For questions about the collection of personal information, please contact the Town of Olds ATI Coordinator at ATIRRequests@olds.ca.