



# Referral Form

*Addiction Services for York Region provides assessment, treatment and case management services to clients and their families aged 12 and older with substance use and gambling problems. Services may vary based on program mandates.*

Client's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Client's Phone: \_\_\_\_\_

Can identifying message be left stating that ASYR is calling?  Yes  No

Referring Organization: \_\_\_\_\_

Name of Referrer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Reason for referral:

- Substance use, please specify the substance(s): \_\_\_\_\_
- Gambling
- Family Member/Significant Other

Additional Comments: \_\_\_\_\_

\_\_\_\_\_  
CLIENT'S SIGNATURE FOR CONSENT TO CONTACT

\_\_\_\_\_  
DATE

**VERBAL CONSENT OBTAINED** (PLEASE ✓ IF UNABLE TO OBTAIN CLIENT'S SIGNATURE)

*\*PLEASE NOTE: REFERRALS WILL NOT BE ACCEPTED WITHOUT THE CLIENT'S CONSENT\**

Please **fax form** (no other documentation is needed) to **905-841-6146**

Attention: Intake Department or email: [intake@asyr.ca](mailto:intake@asyr.ca)

*Please note that 3 attempts will be made to contact the client, upon which the referral will be shredded. Clients are welcome to call directly to speak with an Intake Coordinator.*

Call **Intake** at **905-841-7007** (ext. 322) for further enquiries.