



Capital City Volunteers
connecting generations / enhancing independence

DATE: _____

REFERRAL FORM

Individual has given consent to be referred to Capital City Volunteers: YES NO

Please note: This request cannot be processed without prior consent. Self-referrals welcome.

Volunteer services may be available for low income seniors or adults with disabilities who are living independently in the City of Victoria (except James Bay) and at considered to be risk of isolation. "Low income" as defined by Revenue Canada is someone earning below \$30,000.

Individual's Name: _____

Address: _____ Postal Code : _____

Telephone: _____ Date of Birth: _____

E-mail &/or Cell Phone: _____

Lives Alone? YES NO Any health or safety concerns in the home? YES NO

If "Yes," please specify (Please include any previous bedbug concerns):

Health Concerns (including addictions &/or mental health issues):

Reason for referral:

Please complete this section if this is not a self-referral:

Your Name: _____

Telephone: _____ Email: _____

Name of Organization/Position/Role: _____

Fax: 250-388 7856 or e-mail: info@capitalcityvolunteers.org . This is a confidential document.

UPDATED MARCH 2016

Please include information that will help us prepare the right volunteer or program for this individual. Substance abuse or any other behavior that may be challenging for an untrained person is important for us to know about. This form is a confidential document viewed only by staff. Thank you.