Referral to SAFExst – *The Centre*

Today's Date: ___________________________

Referring Agent (Name, Organization): ____

____

Contact Information: ____

Please have client fill out secondary page

Please forward both pages of referral form

Fax: **<u>236-422-0016</u>**

E-mail: **<u>thecentre@sowins.com</u>**

Drop off in-person to Reception at: **<u>SOWINS Head Office; 102-1027 Westminster Ave West.</u>**

~ The SAFExst Team will review this form and confirm whether a client is suitable for the program. ~

The information provided on this sheet is confidential and used only as a means to assess a client's suitability for our program.

Referral to SAFExst – *The Centre*

The Centre is a resource for people who work in the sex trade and are experiencing a range of marginalizing circumstances such as poverty, homelessness, exploitation, and/or engaging in sex work as a way to survive.

Last Name: ______________________ **First Name:** _________________________

Birthdate: __________ **Phone Number:** ____________ **Is it safe to call?** Yes ☐ No ☐ **Text?** Yes ☐ No ☐

E-mail: ____________________________________

Do you have any children? Yes ☐ No ☐

If yes, are they in your care? Yes ☐ No ☐

Is The Ministry of Child and Family Development Involved? Yes ☐ No ☐

Are you currently homeless? Yes ☐ No ☐

Have you ever experienced abuse?

Physical ☐ Emotional ☐ Verbal ☐ Financial ☐ Sexual ☐ Psychological ☐

Are you still being abused? Yes ☐ No ☐

Do you live with this person? Yes ☐ No ☐

Are you, or have you ever been involved in sex work? Yes ☐ No ☐

Do you identify as having an addiction? Yes ☐ No ☐

What services do you need at this time?

Help getting ID ☐ Applying for Income Assistance ☐ Attending Court ☐ Attending Court ☐

Food Security ☐ Access to Laundry/Shower/Meals ☐ Completing Housing Applications ☐

Mental Health Support ☐ Addiction Support ☐ Help Finding a Doctor ☐ Making a Safety Plan ☐

Other ☐ : ____

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