



# LEGAL HELP REFERRAL FORM

**COMPLETED FORMS CAN BE FAXED TO CALC: 613-966-6251 or SCAN & EMAIL TO: [contact@calc.clcj.ca](mailto:contact@calc.clcj.ca)**

**Please call Legal Aid Ontario for family or criminal law help: 1-800-668-8258**

Date:

Referred by (your name):

Your Organization:

Your number and/or email:

## **PATIENT/CLIENT INFORMATION:**

First name:

Last name:

Pronouns:

DOB:

Address:

Phone number:

Alternate number:

Ok to leave msg: Yes ☐ No ☐

Notes (requires interpreter, best time to contact, etc):

## **REASON FOR REFERRAL:**

- ☐ **Housing** (e.g., tenant rights, evictions)
- ☐ **Income** (e.g., Ontario Works, ODSP, CPP, Disability Tax Credit, Child Tax Benefit)
- ☐ **Employment** (e.g., employment insurance, wrongful dismissal, sexual harassment)
- ☐ **Worker's Compensation / WSIB** (e.g., benefits denied, benefits stopped, unsafe work)
- ☐ **Consumer & Debt** (e.g., collection agencies, door-to-door sales, bank garnishment, small claims court lawsuits)
- ☐ **Seniors' Law** (e.g., wills, issues with retirement homes, Old Age Security, elder abuse)
- ☐ **Human Rights / Discrimination** (e.g., in housing, education, work)
- ☐ **Education** (e.g., unmet needs in special education, suspensions/expulsions)
- ☐ **Powers of Attorney**
- ☐ **Other:**

## **Brief description of issue(s):**

I, the client/patient named above, authorize the referring health organization to release my contact information to the Community Advocacy & Legal Centre (CALC). I understand that CALC is a non-profit community legal clinic providing free legal services to low-income residents of Hastings, Prince Edward and Lennox & Addington counties. I understand CALC will make reasonable efforts to contact me in order to provide information and/or legal advice and/or referrals with respect to my legal issue, but that CALC is not retained in this matter, and is not responsible for any matters arising if I cannot be reached. I give CALC permission to advise the referring health organization if I cannot be reached.

DATE: \_\_\_\_\_

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
PATIENT SIGNATURE