181 Victoria Street West
Kamloops, BC, V2C 1A5
Phone: 825.222.4681
Fax: 855.975.2566
wellnesskam@theseed.ca

HEALTH & WELLNESS REFERRAL FORM

REFERRAL DETAILS

DATE OF REFERRAL: _____

REFERRAL AGENCY: _____ WORKER NAME: _____

PHONE: _____ FAX: _____

EMAIL: _____

*IS THE PATIENT AWARE, AND HAVE THEY CONSENTED TO THIS REFERRAL? ☐ YES ☐ NO
If this person is not aware, they will not be contacted

PATIENT DETAILS

FIRST NAME: _____ SURNAME: _____

GENDER IDENTIFICATION: _____ DATE OF BIRTH: _____

PHONE: _____ EMAIL: _____

*CAN A STAFF/AGENCY IDENTIFYING VOICEMAIL BE LEFT FOR THE PATIENT? ☐ YES ☐ NO

STREET ADDRESS: _____

PROVINCE: _____ POSTAL CODE: _____

PERSONAL HEALTH NUMBER: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE: _____

DOES THE CLIENT HAVE A FAMILY PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN DETAILS

NAME: _____ PHONE: _____

ADDRESS: _____

_____

REQUESTED ACTION

- ☐ Advocacy Services
- ☐ Chaplaincy / Spiritual Care
- ☐ Foot Care
- ☐ Mental Health Counselling
- ☐ Nursing
- ☐ Taxes

If requesting Advocacy services, please select an options:

- ☐ General Advocacy
- ☐ Housing
- ☐ Identification
- ☐ Income Support
- ☐ Seniors Supports

REASON FOR REFERRAL

PRINT REFERRAL FORM AND FAX TO
1 – 855 – 975 – 2566