WELLNESS CENTRE REFERRAL

Date:	Referral Source:	Phone: Fax:
Client Name:		Gender:
DOB:	Phone (client):	PHN:
Address:		
Family Physician & Physician Fax Number:		
Guardian/Appointed Agent *(if applicable)*:		
Phone *(if applicable)*:		Relationship:

Referral Information

Reason for referral:

Type of referral
□ New referral □ Current/Previous Mustard Seed Client

Past Relevant Medical History:
□ Additional Information Attached

Requested Action

□ Functional Cognitive Assessment (Adult)* □Sensory Assessment (Child/Adult) □ Motor Function Testing (Child/Adult) □ Psycho-educational testing (Child/Adult)* □ FASD Testing (Adult)* **Please only choose one – if more than one is selected, the referral will be returned.*	□ Advocacy (Adult/Family/Youth) □General Counselling (Child/Adult/Family) □ Addictions Counselling (Adult) □ Indigenous Counselling (Child/Adult)

Name	Signature	Designation	Date *(yyyy-mon-dd)*

Please Fax to 1-855-927-1705