11355 105 Ave., Edmonton AB
T5H 3Y3
PH: 825-222-4816
Fax: 833.381.0920
HealthandWellnessEDM@theseed.ca

Health and Wellness Referral Form

Please complete and fax form to 833.381.0920

Date: _____

Referral Source: _____

Phone: _____ Fax: _____

Email: _____

**Is the patient aware, and have they consented to this referral:* _____

Patient Details

Title: _____ First Name: _____ Surname: _____

Gener: _____ Address: _____ Province: _____

Date of Birth: _____ Postal code: _____

Health Care Number: _____ Phone: _____

**Can a staff/agency identifying voice mail be left for patient?:* _____

Family Physician: _____ Physician Contact: _____

Emergency Contact

First Name: _____ Surname: _____

Relationship: _____ Phone Number: _____

Requested Action

Please only choose one	***If requesting counselling, please answer all the questions below:***
☐ Functional Cognitive Assessment (Adult) ☐ Motor Function Testing (Adult/Child) ☐ Mental Health Counselling ☐ Advocacy – General ☐ Advocacy – ID ☐ Advocacy – Income ☐ Advocacy - Housing	☐ General Mental Health Counselling (Adult) ☐ General Mental Health Counselling (Youth 14+) ☐ Addictions Counselling **Location Preferred:** ☐ 11355 105 Ave. ☐ Video/Phone Counselling

please finish application on next page

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Reason for Referral:

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