



**181 Victoria Street West  
Kamloops, BC, V2C 1A5**

Phone: 825.222.4681  
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**

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**Please email a copy of this filled out form to:  
WellnessKAM@theseed.ca**

