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T2G 1B3
Ph: 587.393.4020
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wellnesscgy@theseed.ca

Health and Wellness Referral Form

Date:_____

Referral Source:_____

Phone:_____ **Fax:**_____

Email:_____

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

Patient Details

Title:_____ **First Name:**_____ **Surname:**_____

Gender:_____ **Address:**_____ **Province:**_____

Date of Birth:_____ **Postal Code:**_____

Health Care Number:_____ **Phone:**_____

Family Physician:_____ **Physician Contact:**_____

Can a staff/agency identifying voicemail be left for patient? ***Yes*** ☐ ***No*** ☐

Emergency Contact

First Name:_____ **Surname:**_____ **Relationship:**_____

Phone Number: _____

Requested Action

Please only choose one- if more than one is selected, referral will be returned.	***If requesting counselling, please answer all the questions below.***
❑ Functional Cognitive Assessment (Adult) ❑ Motor Function Testing (Adult/Child) ❑ FASD Assessment (Adult) ❑ Advocacy ❑ Physiotherapy ❑ Mobile Outreach Services ❑ Foot Care ❑ Veterans Support ❑ Psychoeducational Assessments (Youth 6-12)	❑ General Mental Health Counselling (Adult) ❑ General Mental Health Counselling (Youth 14+) **Location preferred for counselling:** ❑ Downtown (1010 Centre Street S) ❑ Marlborough (#24- 6060 Memorial Dr.) ❑ Video/Phone Counselling

*Please finish application on next page**

*Please fax form in once completed or bring back in person**

Reason For Referral:

If requesting Mobile Outreach Services, please note where the client can be located*

Please be advised that upon availability you may be added to a waitlist. Once an appointment becomes available for you, you will be contacted for booking*