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WellnessKam@theseed.ca

Health and Wellness Referral Form

Date: _____

Referral Source: _____

Phone: _____ Fax: _____

Email: _____

Patient Details

Title: _____ First Name: _____ Surname: _____

Gender: _____ Address: _____ Province: _____

Date of Birth: _____ Postal Code: _____

Health Care Number: _____ Family Physician: _____

Phone: _____ Physician Contact: _____

Emergency Contact

First Name: _____ Surname: _____ Relationship: _____

Phone Number: _____

Requested Action

- Tax Clinic
- Advocacy
- Foot Care
- Identification
- Employment Support
- Senior Supports
- Housing Supports
- Addiction and Recovery Supports
- Spiritual Care/Chaplaincy
- Mental Health & Counselling Supports

Reason For Referral:

