11355 105 Ave., Edmonton AB
T5H 3Y3
PH: 780.426.5600
Fax: 833.381.0920
edmclinica@theseed.ca

Health and Wellness Referral Form

Date: _____

Referral Source: _____

Phone: _____ Fax: _____

Email: _____

Patient Details

Title: _____ First Name: _____ Surname: _____

Gener: _____ Address: _____ Province: _____

Date of Birth: _____ Postal code: _____

Health Care Number: _____ Phone: _____

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) ☐ Psychoeducational Assessment (Adult/Child) ☐ Physiotherapy ☐ Addictions Support ☐ Advocacy ☐ Motor Function Testing (Adult/Child) ☐ FASD Assessment (Adult) ☐ Diabetic Foot and Wound Care ☐ Mental Health Counselling	☐ 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:

please finish application on next page