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Ph: 587-393-4930
Fax: 1-855-927-1705
wellness@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 Card Number: _____ Family Physician: _____

Phone: _____ Physician Contact: _____

Emergency Contact

First Name: _____ Surname: _____ Relationship: _____

Requested Action

Please only choose one – if more than one is selected, the referral will be returned.	***If requesting counselling, please answer all questions below.***
○ Functional Cognitive Assessment (Adult) ○ Motor Function Testing (Child/Adult) ○ Psychoeducational Assessment (Child/Adult) ○ FASD Assessment (Adult) ○ Advocacy (Adult/Family/Youth)	○ General Mental Health Counselling (Adult) ***OR*** ○ Indigenous Counselling (Child/Adult) Have you ever accessed counselling before? Yes No Have you accessed counselling at The Mustard Seed before? If yes, with who and when?

Reason for Referral
