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Health and Wellness Referral Form

Date: _____

Referral Source: _____

Phone: _____ Fax: _____

Email: _____

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

If this person is not aware of this referral, they will not be contacted

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

<p><i>Please only choose one- if more than one is selected, referral will be returned.</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Functional Cognitive Assessment (Adult) <input type="checkbox"/> Motor Function Testing (Adult/Child) <input type="checkbox"/> FASD Assessment (Adult) <input type="checkbox"/> Advocacy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Diabetic Foot and Wound Care <input type="checkbox"/> Addictions Mobile Outreach 	<p><i>If requesting counselling, please answer all the questions below.</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> General Mental Health Counselling (Adult) <input type="checkbox"/> General Mental Health Counselling (Youth 14+) <p>Location preferred for counselling:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Downtown (Except youth) (1010 Centre Street S) <input type="checkbox"/> Marlborough Park (6060 Memorial Dr NE) <input type="checkbox"/> Video/Phone Counselling
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Please finish application on next page

Please fax form in once completed or bring back in person

Reason For Referral:

If requesting Addictions Mobile Outreach, 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