De dwa da dehs nye>s Aboriginal Health Centre

We're Taking Care of Each Other Amongst Ourselves.

Please Fax Completed form to: 1-844-594-2334

Mental Health Services External Referral Form

Client Information:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Status: (First Nations, Métis, Inuit, non status)

Address at time of referral: _____

Contact number at referral _____ Email _____

Referral Source:

Name of Referring Individual: _____ Title: _____

Name of Organization: _____

Address: _____

Contact Number: _____ ext: _____ Fax Number: _____

Email: _____

Reason for Referral & additional Comments:

_____

_____

_____

What services are you referring to (check all that apply):

☐ Child and Youth Counselling	☐ Adult Counselling	☐ Addictions Counselling	☐ Adult Peer Support
☐ Child and Youth Navigation/Case management	☐ Adult Mental Health Case Management	☐ Addictions Navigation/Case Management	

***Verbal consent obtained:** ◯ Yes ◯ No

I _____ consent to my information being shared on this form to the AHC

_____ _____

Signature of client for written consent Date

_____ _____

Signature of referral source Date

*** staff will not be able to contact individual if written or verbal consent is not obtained first.**

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