External Mental Health Referral Form

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

CLIENT INFORMATION:

Full Name:

Address:

Email:

Date of Birth: Phone:

Status First Nations,Métis, Inuit, non status:

REFERRAL SOURCE:

Name of Referring Individual:

Name of Organization:

Address:

Contact Phone Number: Ext:

Email:

WHAT SERVICES ARE YOU REFERRING TO (CHECK ALL THAT APPLY) :

☐ Child & Youth Counselling	☐ Adult Counselling	☐ Addictions Counselling	☐ Adult Peer Support
☐ Child & Youth Navigation / Case Management	☐ Adult Mental Health Case Management	☐ Addictions Navigation / Case Management	☐ Adult Outreach/RAAM Counsellor

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REASON FOR REFERRAL & ADDITONAL COMMENTS:

AUTHORIZATION FOR RELEASE OF INFORMATION:

I, _____ , authorize De dwa da dehs nye>s Aboriginal Health Centre to:

a) Create a patient chart within our electronic medical record and,

b)Communicate and exchange my personal health information with

[NAME OF PERSON COMPLETING FORM] _____

for the purpose of providing, coordinating and continuing care that is in my/the patients best interest.

You may withdraw this consent at any time. All information will be maintained CONFIDENTIAL between all parties involved.

Name of person completing this form: _____

Relationship to Client: _____

Email: _____

Phone: _____ Fax: _____

Signature of Client: _____