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:

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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	❑ Psychiatry (Only available if another service is checked)

***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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