



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):

<input type="checkbox"/> Child and Youth Counselling	<input type="checkbox"/> Adult Counselling	<input type="checkbox"/> Addictions Counselling	<input type="checkbox"/> Adult Peer Support
<input type="checkbox"/> Child and Youth Navigation/Case management	<input type="checkbox"/> Adult Mental Health Case Management	<input type="checkbox"/> 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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