CLIENT REFERRAL FORM

Turning Point Program
Phone: (403)881-3920
Fax: (403)881-2174

Date: _____

Name: _____

DOB: _____ Age: _____ Gender: ____ M ____ F ____ Prefer not to specify

Address: _____

Alarm #: _____

Phone #: _____ AHC #: _____

OK to leave a message? ____Y ____ N

Presenting Concern(s) and Symptoms:

- ☐ Addiction (Alcohol, Gambling, Prescription Drugs, Street Drugs)
- ☐ Adjustment/ Life Transition Issues
- ☐ Anger Management
- ☐ Anxiety
- ☐ Bereavement/ Loss
- ☐ Child/ Adolescent Behaviour Issues
- ☐ Depression
- ☐ Elder Abuse
- ☐ Disaster Recovery
- ☐ Employment Career Related
- ☐ Family Violence/ Abuse
- ☐ Housing
- ☐ IRS Related Issues
- ☐ Marital/ Relationship Issues
- ☐ Parenting
- ☐ Physical Health Issues
- ☐ Reaction to Critical Incident
- ☐ Self-Injurious Behaviour/ Suicidal Ideation
- ☐ Sexual Abuse/ Assault
- ☐ Other _____

Name & Location of Physician: _____

Other healthcare provider (ie. Psychiatrist, Psychologist, Counselor):

_____

Service Providers Rationale (How are you hoping Turning Point will help your client reach his/her goals?)

*****Please provide copy of the probation order*****

Referral Source (Name): _____

Agency: _____ Phone #: _____

Email: _____

RETURN VIA FAX ONLY TO 403-881-2174