



# CLIENT REFERRAL FORM

**Mental Wellness Programs**  
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 Referrer:** \_\_\_\_\_

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

\_\_\_\_\_

**Service Providers Rationale** (How are you hoping our programs will help your client reach their goals?)

**Please provide copy of the probation order (if applicable)**

Referral Source (Name): \_\_\_\_\_

Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

**RETURN VIA SECURE AND CONFIDENTIAL FAX ONLY TO 403-881-2174**