Mental Health Referral/Consult Form

an(If patient is under the age of 18, please include parent/guardian name and phone number)

Name *(Parent/Guardian)*:

_____

Phone: _____

Alternate Phone: _____

Patient Label

REASON FOR REFERRAL/CONSULT

□ **PATIENT IS AWARE OF THIS REFERRAL**

□ Abuse Issues
□ Addictions
□ Adjustment to Illness
□ Anger
□ Anxiety
□ Behavioral Issues
□ Community Resourcing
□ Depression
□ Education
□ Geriatric
□ Grief
□ Marital Issues
□ Parenting Issues
□ Psychiatry
□ Stress
□ Self Esteem
□ Separation/Divorce
□ Other

_____

_____

Additional Comments

NOTE: URGENT REFERRALS SHOULD BE DIRECTED TO AHS MENTAL HEALTH AT PHONE 780-342-3373 or FAX 780-342-3649.

REFERRING PHYSICIAN

Referred by (PLEASE PRINT): _____Clinic Name_____

Date of Referral: _____ Physician SIGNATURE:_____

PHONE: _____ FAX: _____

Sherwood Park – Strathcona County Primary Care Network – Mental Health Services
150 Broadway Cres, Sherwood Park, AB T8H 0V3 Tel: (780) 410-8011 Fax: (780) 410-0184

FOR OFFICE USE ONLY:

APPOINTMENT DATE: _____ **CASE ASSIGNED TO:** _____

Updated – May 2016