

Community Psychiatry Referral Form

Client Information

Client Name:		PHN/Alberta Health Care:	
Date of Birth:	Gender:	Pronouns:	
Client Address:		City	Postal Code:
Primary Phone:		Email Address:	

Is the client aware of the referral? Yes Is the client in agreement of the referral? Yes

Referral Information

Is the referral <input type="checkbox"/> Urgent or <input type="checkbox"/> Routine?		Care sought*: <input type="checkbox"/> Consult <input type="checkbox"/> Short-term <input type="checkbox"/> Ongoing	
Appointment type sought: <input type="checkbox"/> In-person <input type="checkbox"/> Virtual <input type="checkbox"/> Both			
Referral Source Name:		Clinic/PCN:	
PraclD:	Phone:	Fax:	
Client Address:		City	Postal Code:

Attachments: Medical and psychiatric history Current medications Other information

Current Mental Health Supports

Please Describe:

Reason for Referral to Community Psychiatry

Types of Services/Assessments Sought

Please Describe:

Risks