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Health and Wellness Referral Form

Date: _____

Referral Source: _____

Phone: _____ **Fax:** _____

Email: _____

Patient Details

Title:_____First Name:_____Surname: _____

Gender: _____ Address: _____ Province: _____

Date of Birth: _____ Postal Code: _____

Health Card Number:_____Family Physician: _____

Phone: _____ Physician Contact: _____

Emergency Contact

First Name:_____ Surname:_____ Relationship:_____

Requested Action

Please only choose one – if more than one is selected, the referral will be returned. ☐ Functional Cognitive Assessment (Adult) *Coming Soon ☐ Motor Function Testing (Child/Adult) *Coming Soon ☐ Functional Equipment (Adult) *Coming Soon ☐ Advocacy (Adult/Family/Youth) ☐ General Mental Health Counselling (Adult)	*If requesting counselling, please answer all questions below.* *Have you ever accessed counselling before?* ☐Yes ☐No Have you accessed counselling at The Mustard Seed before? If yes, with who and when?

Reason for Referral
