Regina Qu'Appelle HEALTH REGION

MENTAL HEALTH & ADDICTION SERVICES
CENTRAL REFERRAL MANAGMENT **FAX: 306-766-7811**

If this is Emergent, please phone Intake at 306-766-7800. For all referrals submitted using this form, follow-up patient contact for screening will occur in 1-2 business days.

Adult Referral (18+Years)

CLIENT INFORMATION	Client Name:		
Date of Birth: YYYY/MM/DD	Address:		
City:	Prov:	PC:	HSN:
Best Daytime Phone Number:		☐ No telephone	
Email Address:			
Client accommodations: ☐ Requires interpreter ☐ Other (specify):			

REFERRAL INFORMATION

☐ Physician
☐ Nurse Practitioner
☐ Other (Specify):_____

Name of referring individual/agency:_____
Address: _____
Phone: _____
Fax: _____

REFERRAL TO:

☐ Mental Health – Adult Psychiatry

Please specify how you would like your referral directed:

- Direct my referral to the following psychiatrist: _____
- Direct my referral to the next available psychiatrist.

  If you have selected the next available, are there any psychiatrists you would like to exclude? _____

☐ Mental Health – Other Therapy Services

- Request: _____

Does this client know that they are being referred for Mental Health and Addiction Services? ☐ Yes

REASON FOR REFERRAL: **(PLEASE INCLUDE CURRENT MEDICATIONS AND MENTAL HEALTH HISTORY. IF YOU HAVE PREPARED A REFERRAL LETTER, YOU MAY LEAVE THIS SECTION BLANK.)**

Referring Practitioner Signature:	Date: