PrimaryCare Network WESTVIEW

Youth Mental Health Clinic

Youth Ages 11-25

Fax: (780) 960-9591 | Phone: (780) 960-9533

REFERRAL FORM

Patient Information				
Last Name	First Name		Int.	Male ☐ Female ☐ Other/Not specified ☐
Address	City/Town		Prov.	Postal Code
Patient Phone Number	Email Address			
PHN	DOB (dd/mm/yyyy)	Occupation		
Parent/Guardian Name & Phone Number:				
Is patient aware of referral? ☐ Yes ☐ No	Contact Preference:	☐ Contact the **parent or guardian** for appointment ☐ Contact the **patient directly** for appointment		
Is the patient connected to any other social or mental health services in the community? ☐ Yes ☐ No If yes, who/where?				
Are there any other pending mental health referrals we should be aware of? ☐ Yes ☐ No If yes, where?				
Are there any custody or court orders that we should be aware of? ☐ Yes ☐ No				
* **Please attach any previous mental health consults or psychoeducational assessments.**				

Diagnosis
Clinical concerns: (please print and use back of form if you need extra space)
Current medications: (please print and use back of form if you need extra space)

Referring Health Care Professional Information			
Last Name	First name	PRAC-ID (if applicable)	
Clinic Name		Phone Number	
Address	City/Town	Prov.	Postal Code
Email Address		Fax	

Please include all available associated medical documentation with this referral.

Health Care Professional Signature ________________ Date ________________

Please fax referral form to (780) 960-9591.

Last edited July 31st, 2023