

Clinical Health Psychology

Referral Form

Client's name _____

Address _____

Postal Code _____

Phone _____ Phone (Alt): _____

D.O.B.: (dd/mm/yyyy) ____/____/____ Male ___ Female ___

PHIN _____ MHSC _____

Contact person _____ Phone _____

Name of referring person: _____

Phone _____ Fax _____

Address _____

Signature _____ Date _____

Family physician (if not referring person) _____

Other relevant treatment services _____

<i>Referral for (check)</i>	<i>Assessment/consultation</i>	<i>treatment</i>	
-----------------------------	--------------------------------	------------------	--

IMPORTANT: For 'treatment' referrals requesting help with both Depression and Anxiety, please indicate which is the most severe, or impairing of the two.

Reason for referral: _____

Relevant health / medical issues / medications / social issues:

Referrals are accepted directly from WRHA program service teams and physicians in the community. Referral form can be sent to the service/site or to the central referral service at:

Clinical Health Psychology
Psychealth, Health Sciences Centre
771 Bannatyne, Winnipeg MB R3E 3N4
FAX: 787-3755