Primary Care Network
CAMROSE

CAMROSE | BASHAW | DAYSLAND
FORESTBURG | HARDISTY

Last Name _____ **First Name** _____

PIN _____ **Gender** _____

Address _____

_____

DOB _____ **Home Phone** _____

Work Phone _____ **Cell** _____

PCN Behavioral Health Consultant (BHC) or AHS Community Addiction & Mental Health Referral Form

Phone: 780.608.4927
Fax: 780.608.4931

Date of Referral _____ Referral Physician _____

Family Physician _____ Phone _____ Fax _____

Date of next follow-up appointment with Physician (if any) _____

(If patient is under the age of 18, please include parent/guardian name and phone number): Name _____ Phone _____

Are there any risks to Staff Safety *(describe concerns below)* ☐ Yes ☐ No ☐ Maybe

Is this referral urgent *(describe concerns below)* ☐ Yes ☐ No

Does the patient consent to this referral? ☐ Yes ☐ No

Patient consents to phone message being left to book appt? ☐ Yes ☐ No

PCN Behavioral Health Consultant (BHC) referral *for*

- ☐ Abuse Issues
- ☐ Adjustment to Illness
- ☐ Behavioral Issues
- ☐ Cancer Support
- ☐ Community Resourcing
- ☐ Education
- ☐ Financial Concerns
- ☐ Grief
- ☐ Marital Issues
- ☐ Parenting Issues
- ☐ Stress
- ☐ Self Esteem
- ☐ Separation/Divorce
- ☐ Other: _____

AHS Community Addiction & Mental Health *for*

☐ Addiction ☐ Mental Health - Adult ☐ Mental Health – Children/Youth

☐ Client has spoken with Camrose Addiction & Mental Health and has an appointment ☐ Yes ☐ No

If yes, appointment date & time _____

☐ Client requesting to be seen at Smith Clinic

Please describe concerns: (Attach current med list if recently started on new medications)

PHYSICIAN SIGNATURE: _____

Revised Feb 2018