



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 _____ Family Physician _____

Referred by ☐ Physician _____ Phone _____
☐ Self ☐ Other _____ Phone _____

(If patient/client 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/client consent to this referral? ☐ Yes ☐ No

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

PCN Behavioral Health Consultant (BHC) referral for

- | | |
|--|--|
| <input type="checkbox"/> Abuse Issues | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Adjustment to Illness | <input type="checkbox"/> Marital Issues |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Cancer Support | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Community Resourcing | <input type="checkbox"/> Self Esteem |
| <input type="checkbox"/> Education | <input type="checkbox"/> Separation/Divorce |
| <input type="checkbox"/> Financial Concerns | <input type="checkbox"/> Youth Hub Support (age 11 – 24 yrs) |
| <input type="checkbox"/> Other: _____ | |

AHS Community Addiction & Mental Health for

- ☐ Addiction ☐ Mental Health - Adult ☐ Mental Health – Children/Youth
- ☐ Patient/Client has spoken with Camrose Addiction & Mental Health and has an appointment
Appointment date & time _____
- ☐ Patient/Client requests to be seen at Smith Clinic

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