



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

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**

- Abuse Issues
- Adjustment to Illness
- Behavioral Issues
- Cancer Support
- Community Resourcing
- Education
- Financial Concerns
- Other: \_\_\_\_\_
- Grief
- Marital Issues
- Parenting Issues
- Stress
- Self Esteem
- Separation/Divorce
- Youth Hub Support (age 11 – 24 yrs)

**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)