Primary Care Network CAMROSE

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

AHS Community Addiction & Mental Health for: **(Please complete AHS Generic Referral)**

Addiction Mental Health - Adult Mental Health – Children/Youth

PCN Behavioral Health Consultant (BHC) referral *for*

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

Please describe concerns: