Last Name ______________________ First Name ____________________

PIN _____________________________ Gender _______________________

Address ____

____

DOB ________________________ Home Phone ______________________

Work Phone ___________________ Cell ___________________________

PCN Behavioral Health Consultant (BHC) 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**

Behavioral Health Concerns *for*

- ☐ Anxiety (Mild-Moderate)
- ☐ Depression (Mild-Moderate)
- ☐ Behavioral Issues
- ☐ Chronic Health Conditions
- ☐ Self Esteem
- ☐ Grief
- ☐ Relationship Issues
- ☐ Treatment/Medication Adherence
- ☐ Stress
- ☐ Other: ______________________________

Social Concerns *for*

- ☐ Finances
- ☐ Housing
- ☐ Community Resourcing
- ☐ Health Benefit Navigation
- ☐ Social Program Navigation
- ☐ Other: ______________________________

Group Programs *for*

- ☐ Anxiety to Calm
- ☐ Happiness Basics
- ☐ Relationships in Motion
- ☐ Journeying Through Grief

Please describe concerns:

To refer to AHS Community Addiction and Mental Health please use AHS Generic Referral Form.

Revised December 2023