Patient Referral Form

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Integrative Wellness and Psychiatry

Referring Physician Information

Referring Physician Name:

Practice Name/Clinic:

Phone Number:

Fax Number:

Email Address:

Patient Information

Full Name:

Date of Birth:

Personal Health Number:

Address:

Phone Number:

Email Address:

Preferred Contact Method:

Referral Type

Alberta Health Covered Service (Select specific service):

Reason for Referral

Primary Concern/Provisional Diagnosis:

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Specific Questions to be Addressed:

Urgency Level:

Relevant Medical History

Previous Psychiatric Diagnoses:

Relevant Medical Conditions:

Previous Treatments and Response:

Current Medications

Medication Name, Dose, Frequency:

Start Date:

Response/Side Effects:

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Additional Information

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Risk Factors:

Substance Use History:

Is there a history of violence? (Y/N, with details):

History of Psychosis (Y/N, with details):

Attached Documents? (Y/N):