SunCountry HEALTH REGION

Mental Health and Addiction Services

Referral for Services

Attention: Intake Office
Office Hours: Monday to Friday 8:00 a.m. – 4:30 p.m.
Fax Number: (306) 842-1261
Phone Number: (306) 842-8665

Date: (dd/month/yyyy)	**Health Services Number:**	**Date of Birth:** (dd/month/yyyy)	**Gender:** ☐ Male ☐ Female
Last Name:	**First Name:**	**Maiden Name:**	
Address:			**Postal Code:**
Phone (Home): Message: ☐ Yes ☐ No	**Phone (Work):** Message: ☐ Yes ☐ No	**Phone (Cell):** Message: ☐ Yes ☐ No	
Email Address:			
Marital Status:	☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Widowed		
Next of Kin:		**Phone:**	
Allergies:			
Medications:			
Other Agency Involvement:			

Reason for Referral:

- ☐ **COUNSELLING**
- ☐ **PSYCHIATRIC CONSULTATION**
- ☐ **CHANGEWAYS**
- ☐ **PSYCHOLOGICAL TESTING**
- ☐ **ADDICTIONS**

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Has above person given consent for intended involvement with our Service? ☐ **Yes** ☐ **No**

Has above person given consent to be contacted by email? ☐ **Yes** ☐ **No**

Has above person given consent to receive text message alerts? ☐ **Yes** ☐ **No**

If a minor, please complete the following:

Grade: _____ School: _____

Parents or Legal Guardian: _____

Signature of Parents or Guardian: _____ Date: _____

_____
Printed name of referring person

_____
Signature of referring person

_____
Position

Physician/Agency: _____

Address: _____

_____

Phone: _____