Patient Counselling Referral Form

Completed by: ______________________________
Date: _________/_________/________
Day Month Year
Client's Phone Number: ________________________Home
________________________Work
________________________Cell

Has the client or responsible party been notified of the referral? ☐ Yes ☐No
If yes, is the client or responsible party in agreement with the referral? ☐Yes ☐ No

Addressograph, or Name, Address, Physician, Date of Birth, Health Services No. GMS/MSI

FAX FORM: (306) 842-3166

OR SEND:
Patient Counselling
Weyburn General Hospital,
201 1st Avenue, NE, Weyburn, Sk S4H 0N1

Client is Now Residing:	If Client is in an institution:
☐At Home Alone ☐At Home with ____________________________________ ☐In an institution (Name)______________________________	Admission Date:______________________________ Planned Discharge Date: _______________________ Type of bed occupied:_________________________ Diagnosis: ______________________________________

Referred by:

____ ____
Relationship/Position/Agency

Family/Friends-Designate Main Contact with:

Name	Relationship	Phone Number:
____________________________________	____________________________________	__________________________
____________________________________	____________________________________	__________________________
____________________________________	____________________________________	__________________________

Comments: (include reason for referral and urgency of need)