AAKOM-KIYII HEALTH SERVICES
AKOKA' TSSINI MENTAL WELLNESS
1885 15th St, BROCKET, AB T0K 0H0
PHONE: (403) 965-3919 • FAX: (403) 965-2153

REFERRAL FORM

PARTICIPANT INFORMATION

Date:	
Participant Name:	
Date of Birth:	Gender: M ☐ F ☐ Two Spirited ☐
Indian Status #:	PHN #:
Address:	
Phone Number:	Can staff leave a message? ☐ **Yes** ☐ **No**
Is this a self-referral? ☐ **Yes** ☐ **No**	
If not is the participant aware of the referral? ☐ **Yes** ☐ **No**	
Is this referral urgent? ☐ **Yes** ☐ **No**	

REASONS FOR REFERRAL (EXPLAIN WHY YOU ARE COMPLETING THIS REFERRAL. WHAT ARE THE PRESENTING CONCERNS/BEHAVIOURS? WHAT PROGRAM OR STAFF MEMBER ARE YOU WANTING TO CONNECT THEM TO?)

LEGAL INFORMATION (ATTACH COPY OF LEGAL ORDER IF APPLICABLE)

Guardian/Substitute Decision Maker:	☐	Yes	☐	No			
Name:					Phone Number:		
Trustee	☐	Yes	☐	No	Contact Name:	Phone Number:	
PDD	☐	Yes	☐	No	Contact Name:	Phone Number:	
AISH	☐	Yes	☐	No	Contact Name:	Phone Number:	
SOCIAL	☐	Yes	☐	No	Contact Name:	Phone Number:	
Probation Order	☐	Yes	☐	No	Contact Name:	Phone Number:	

PARTICIPANT HISTORY (MEDICATIONS, HOSPITALIZATION, PSYCHOSIS, DIAGNOSIS, ASSESSMENTS, SUBSTANCE USE)

REFERRING AGENCY OR PERSON

Referred By: _____ Position/Agency: _____

Contact Number: _____ Date of Referral: _____

Signature: _____