rivers edge

COUNSELLING CENTRE

PATIENT REFERRAL FORM

DATE _____

PATIENT NAME _____ DOB _____

PATIENT CONTACT: Home: _____ Cell: _____

PHYSICIAN NAME _____

PHYSICIAN CONTACT: Phone:_____ Fax: _____

REFERRAL SOURCE (if other than physician) _____

REFERRAL CONTACT: Phone:_____ Fax: _____

PRESENTING PROBLEM for Counselling/Psychological Services:

☐ Individual Adult ☐ Child/Adolescent

- ☐ Depression / Post-Partum Depression
- ☐ Anxiety / Panic
- ☐ Addictions (substance, gambling, sex)
- ☐ Trauma / PTSD
- ☐ Stress / Burnout
- ☐ Workplace Issues
- ☐ Career / Vocation
- ☐ Anger Management
- ☐ Personality Issues
- ☐ Other: _____
- ☐ Grief / Loss
- ☐ Relationship Problems
- ☐ Chronic Pain
- ☐ Life Transition
- ☐ ADHD
- ☐ Adjustment Problems
- ☐ ODD / Behaviour Problems
- ☐ OCD
- ☐ Self-Injury/Cutting

☐ Couples - Marriage Counselling

☐ Family Counselling (conflict resolution, parenting support and blended family issues)

Rivers Edge Counselling Centre Inc. A: #204, 14 Mission Avenue | St. Albert | Alberta | T8N 1H4
P: 780.460.0022 F: 780.460.0032 E: info@riversedgecounselling.com W: www.riversedgecounselling.com

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RELEVANT HISTORY (please include any details you feel would be helpful below)

_____ _____

Signature Date

Please Note:

Patients will be contacted by River's Edge Counselling Centre staff within 24 hrs on weekdays.

If patient provides written consent, a letter outlining assessment and treatment plan will be sent to the referring physician to coordinate care.

River's Edge Counselling Centre staff will strive to match each patient with a therapist that best meets their needs in terms of specialization, hours, fees and personality. Our graduate student training program allows us to offer lower cost services to clients with no insurance or the means to pay regular fees. If we cannot meet the specific needs of a patient, we will work together to find an appropriate referral in the community.

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