CARIBOO FRIENDSHIP SOCIETY
Aboriginal Development Clinician Referral Form

CLIENT NAME				REFFERAL SOURCE (Name of referring party)	
				REFFERAL DATE	
GENDER ~M ~F	D.O.B. (YYYY/MM/DD)	PERSONAL HEALTH NUMBER		REASON FOR REFERRAL AND PRESENTING PROBLEMS	
CLIENT ADDRESS				~	Anxiety
				~	Depression
CITY/TOWN			POSTAL CODE	~	Behaviour Problems
					Describe:
CLIENT HOME PHONE NUMBER ( )		CLIENT WORK NUMBER ( )		~	Aggression
				~	Self-harm
NAME OF PARENT(S)/GUARDIAN(S) (IF APPLICABLE):				~	Suicidal
				~	Ideation
				~	Attempt
					Details:
NAME OF PRIMARY PHYSICIAN OR PSYCHIATRIST:				~	Eating Disorder
				~	Substance Abuse
				~	Possible Psychosis
				~	Other: (Describe Below)
PHONE NUMBER ( )					
NAME OF SCHOOL ATTENDED BY CLIENT:					
PREVIOUS MENTAL HEALTH CARE AND DATE(S) (IF APPLICABLE):					
CURRENT MEDICATIONS:				ALLERGIES:	
PAST DIAGNOSIS (IF AVAILABLE):				DOES PHYSICIAN AGREE TO CONSULTATION BY PSYCHIATRIST? Yes ~ No ~	
OTHER RELEVANT MEDICAL INFO:				What is your Aboriginal Ancestry?	
COMMENTS:				Urban ~ Rural ~	
				IS CLIENT AWARE OF THIS REFFERAL? Yes ~ No ~	
SIGNATURE OF REFERRAL SOURCE:				OFFICE USE ONLY RESPONSE DATE:	

FAX FORM TO:
Cariboo Friendship Society
Fax: (250)398-6115
Or Deliver To:
99 South Third Avenue, Williams Lake, BC V2G 1J1