SERDC HEALTH – MENTAL WELLNESS PROGRAM

REFERRAL FORM

Date:	
Completed by:	

What program is the client being referred to? (required)
☐ Tribal NNADAP Program
☐ Mental Wellness Program
☐ IRS Program

IDENTIFYING INFORMATION: (required)		
Last Name:	First Name:	DOB: Treaty #
Last Name:	First Name:	DOB: Treaty #:
Address and Community:		Phone #

CHILDREN (if applicable)				
#	Name	Sex	Age	DOB
1				
2				
3				
4				
5				
6				
7				

WHO CURRENTLY LIVES IN YOUR RESIDENCE (if applicable)				
#	Name	Sex	Age	DOB
1				
2				
3				
4				
5				
6				

OTHER RESOURCES/ WORKERS INVOLVED (required if applicable)		
Name	Role	Phone

Intent of referral to the mental wellness program:

CONSENT TO RELEASE INFORMATION

I, _____ (print name) acknowledge the above care plan, and give my consent for my information to be shared with the following individuals for the purposes of this care plan. Information shared will remain strictly confidential and will only remain on file for as long as necessary after your file is closed.

- ☐ I consent to have my information shared with all relevant staff (including SERDC staff, Health Centre Staff, CFS staff, School staff if necessary)

OR

- ☐ I consent to have my information shared with **only the following individuals:**

_____

_____

_____

_____

_____ _____

Signature DATE

_____

(signature of parent or guardian if under 18)