Abegweit Healing Centre

Mental Wellness & Addictions Support Program

22B Redstone Drive, Scotchfort, PE, C0A 1T0
Phone: 902-731-2105 / Fax: 902-731-2108

REFERRAL FORM

New_______________ Readmission ________________ Date________________________________

Name: _____________________________ Date of Birth: _____________________________________

PHN/Status #:______________________Telephone/Email:___________________________________

Address: ____

Family Physician: ____________________________ Phone: __________________________________

Referred by: ____

Male or Female Clinician (***cannot be guaranteed for caseload purposes***)

- **No preference**
- **Male**
- **Female**

Reasons(s) for seeking counseling:

____
____
____
____

Medication:____
____
____

Have you received previous mental health services? ________

If yes, please explain: ____
____
____

Office Use Only

Manager Signature:___________________ Date:________________

Clinician Assigned:___________________

~Please ensure that the form is completed in full and email to djadis@abegweithealth.ca~
We can only ensure confidentiality when the form is submitted to our office and the original is provided