Rapid Assessment - Request for Services

AHTAHKAKOOP Holistic Wellness Centre
BOX 64
MONT NEBO, SK S0J 1XO
t. 306.468.2027
f. 306.468.2028

Is this a d/c referral from hospital - ☐ **Yes** ☐ **No**

Addiction - ☐

Mental Health - ☐

IS THE CLIENT AWARE THIS REQUEST IS BEING MADE? ☐ **Yes** ☐ **No**

Section A: Referring Healthcare Professional Information

Date: _____ (DD/MM/YY) Referral Time: _____

Referring Professional:

Mental Health Concern: Please provide a specific explanation for request for service vs. one word answer; *e.g.*, "*patient feels sad, hopeless and lonely*" vs "*depression*")

_____

_____

_____

Referring Professional Signature:

Section B: Personal Information

Client Name: _____ Gender: ☐ Male ☐ Female ☐ Other _____

Treaty Status Number: _____

Date of Birth: _____ (DD/MM/YYYY) Age: _____ PHN: _____

Address _____ Please include house number, if applicable: _____

City: _____ Postal Code: _____

Phone #: _____ ☐ Okay to leave message

Other: _____

Emergency Contact Name(s): _____

Phone #: _____

Other: _____

Section C: Medical Conditions

Please list any medical conditions that may be relevant to this referral or important for the RAIT team member to be aware of:

_____

_____

Please drop your completed referral at: AHTAHKAKOOP MENTAL HEALTH & HOLISTIC WELLNESS UNIT
Or fax to 306-468-2028 or email to ahtahkakoopholisticmentalhealth@acn104.ca

Adapted from: Canadian Mental Health Association Lambton Kent