HÔTEL-DIEU GRACE HEALTHCARE

WELLNESS PROGRAM REFERRAL

CRISIS AND MENTAL WELLNESS CENTRE

500 Ouellette Ave.
Phone: 519-257-5224
Fax: 519-973-0613

Date:_____ (MM/DD/YYYY)_____

Admission Criteria

- The client is agreeable and able to participate in group treatment modalities (CBT, DBT)
- The client struggles with emotion dysregulation; moderate to severe anxiety, mood disorders and/or personality disorders
- Substance use and lack of stable basic needs are not interfering with daily functioning
- The client is 16 years of age or older

Surname:_____ First Name:_____ DOB: _____
MM/DD/YYYY

Preferred Name: _____ Health Card #: _____VC_____

Primary Language:_____ Diagnosis: _____

Client Phone #:_____

Can The Wellness Program leave a confidential voicemail? **YES** or **NO** *(please circle response)*

General Practitioner: _____ Psychiatrist:_____

Referral Source:

Agency: _____ Name: _____ Phone#_____

What is the goal of this referral? What is the client expecting from participating in the program?

_____

_____

_____

Form completed by: _____ Signature: _____

Physician/ NP Billing #: _____ Contact Info: _____