



WELLNESS PROGRAM REFERRAL

CRISIS AND MENTAL WELLNESS CENTRE

744 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: _____

