PEARL SPECIALIST CLINIC

Address: Unit 105-10960 42 St NE, Calgary, AB T3N 2B8
Phone: 587-775-4642
Fax: 833-527-4070

PSYCHIATRY REFERRAL FORM – CALGARY NORTHEAST LOCATION

Patient Information

- **Name:** _____ **DOB (YYYY/MM/DD):** _____
- **AB Health Card #:** _____ **Phone:** _____
- **Email:** _____
- **Address:** _____

Referral Urgency

☐ **Routine** ☐ **Semi-Urgent** ☐ **Urgent**

Reason for Referral (check all that apply)

☐ Diagnostic Assessment ☐ Medication Review / Management ☐ Depression / Mood Disorder
☐ Anxiety Disorder ☐ ADHD ☐ PTSD / Trauma ☐ Psychosis ☐ Substance Use ☐ Other:
_____

Brief Clinical Summary / Presenting Concerns

_____

_____

_____

Risk Assessment

☐ Suicidal Ideation ☐ Self-Harm ☐ Homicidal Ideation ☐ None
Details: _____

Current Medications (if any) _____

_____

Referring Provider Information

- **Provider Type:** ☐ Family Doctor ☐ Psychologist ☐ Social Worker
- **Full Name:** _____
- **Prac ID / Billing No.:** _____
- **Phone:** _____ **Fax:** _____
- **Clinic:** _____
-

Consent

I confirm the patient has consented to this referral and release of relevant clinical information.

- **Referring Provider Signature:** _____
- **Date (YYYY/MM/DD):** _____

Kindly fax completed referral form with any supporting documents to 833-527-4070