

PEARL SPECIALIST CLINIC

Address: Unit 2226 – 12 Royal Vista Way, NW Calgary, T3R 0N2

Phone: 587-449-4701

Fax: 833-527-4070

PSYCHIATRY REFERRAL FORM – CALGARY NORTHWEST 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