Wellness Centre

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IFH coverage referral form

Client Information:

First Name---------- **Last Name:** ----------**preferred name**: ----------

Date of Birth (DD/MM/Y): ----------

Unique Client Identifier (UCI#----------

A 9-digit number is on the top right of the refugee claimant document.

Is the client aware of the referral? ----------

Client Address:

Address: ----------

City: ----------Province: ----------Postal code: ----------Unit: ----------

Phone number ----------Email address: ----------

Mental Health Diagnoses: ----------

Psychometric test score: ----------

Medication & start date ----------

Requesting: *Psychotherapy* □ □ *Mental Heath Counselling*

□ *Depression* □ *Anxiety* □ *PTSD* □ *Mood Adjustment Disorder*

Referring Provider Information:

First Name---------- **Last Name**----------

Referring Provider Address: Address: ----------

City: ----------Province: --------Postal Code: ---------- Unit #: ----------

Phone number: ----------Fax: ----------Email: ----------

Signature:

Please submit to

Asma Sleihat MSW RSW **OCSWSSW Registration**# 817253