



Healing Path Wellness Centre

Client Referral Form

The Healing Path Wellness Centre helps bridge the gap between individuals, families and appropriate support services by providing assessment, referrals, and cultural supports.

Individual Name (First, Last)		Birthday (M/D/Y)
Gender Identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	
Address		
Phone Number		Languages Spoken
Email		

<p>Personal/General Life Stressors including stress related to:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Health & Wellness</td> <td><input type="checkbox"/> Addiction</td> </tr> <tr> <td><input type="checkbox"/> Family and relationships</td> <td><input type="checkbox"/> Trauma</td> </tr> <tr> <td><input type="checkbox"/> Employment</td> <td><input type="checkbox"/> Other</td> </tr> </table>	<input type="checkbox"/> Health & Wellness	<input type="checkbox"/> Addiction	<input type="checkbox"/> Family and relationships	<input type="checkbox"/> Trauma	<input type="checkbox"/> Employment	<input type="checkbox"/> Other
<input type="checkbox"/> Health & Wellness	<input type="checkbox"/> Addiction					
<input type="checkbox"/> Family and relationships	<input type="checkbox"/> Trauma					
<input type="checkbox"/> Employment	<input type="checkbox"/> Other					
Notes						

Please complete the following section if this application is **not** a self-referral.

Referred By (Name & Relationship)	
Referral Date (M/D/Y)	Referral Phone Number
Referral Email	

Individual Signature: _____

Date: _____

Referral Signature: _____

Date: _____

If the individual has access to a EAP program through their employer please fill out the back side of this form

EAP Program Eligibility Information

Programs offered through the Healing Path Wellness Centre may be eligible for Employee Assistance Programs. Should EAP services be available to you through your employer please complete the eligibility inquiry below.

Has the employer been notified of this referral? Yes No

If no, please state reason.

Does the individual consent to the employer being contacted to verify coverage?

If no, please state reason. Yes No

I understand there may be limitations of my eligibility in available EAP programs should my employer/manager/supervisor not be aware of the referral.

Employer	
Supervisor / Manager Name	Supervisor / Manager Phone Number

Received By: _____ Date: _____

Contacted on: _____ Contact By: _____

Follow up scheduled? Yes No Follow Up Date: _____