

PEARL SPECIALIST CLINIC

Address: 3240- 28 Kingsview Rd SE Airdrie. AB T4A 3L7

Phone: 587-775-0148

Fax: 587-775-0180

PSYCHIATRY REFERRAL FORM – AIRDRIE 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
- **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 587-775-0180