# Addiction and Mental Health
# Access 24/7 - Community Referral

**A professional referral is not required to access this service.**

**Please feel free to encourage individuals seeking addiction and/or mental health support to contact Access 24/7 by calling 780-424-2424.**

If you are referring from a **Physician office, Primary Care Network or as a health care professional on behalf of a patient or client**, to help us provide the best care possible - please be sure to include the following:

☐ Medical & Psychiatric history
☐ Current medications
☐ Any other information to assist us in ensuring your patient/client will be matched to the right provider or service

Note that missing or inadequate information may delay the intake and scheduling process.

## Questions? Contact us!

**Addiction & Mental Health Access 24/7**
Edmonton Community Health Hub North
13211 Fort Road

Ph: 780-424-2424 | Fax: 587-473-0771

Email referral form to:
EDM.AMHaccess247referrals@ahs.ca

## Addiction and Mental Health Access 24/7
# Community Referral Form

| Date: | To assist us in providing the best care possible, please provide any additional pertinent information with referral form. |
|---|---|
| **Client Information** | |
| Is client aware of the referral? ☐ Yes | Is client in agreement with the referral? ☐ Yes |
| Client Name: | Pronouns: |
| Date of Birth: | PHN/Alberta Health Care: |
| Client Address: | City: Postal Code: |
| Primary Phone: | Client email address: |
| Alternate Phone: | Client agreeable to leave a voice message: ☐ Yes ☐ No |
| Best place to meet the client? | Client preferred contact method: |
| **Referring Information** | |
| Referral source: | Site/Program: |
| Phone Number: | Fax Number: |
| Address: | |
| | |
| **Other Contacts** | ***Attach consent to disclose if applicable** |
| Interpreter required? ☐ Yes ☐ No Language: | Sign Lanaguage? ☐ Yes ☐ No |
| Emergency contact Name:<br>Phone: | Relationship:<br>Client agreeable to leave a voice message: ☐ Yes ☐ No |
| **Other Providers** | ***Attach consent to disclose if applicable** |
| Primary Care Physician: | Phone: |
| Community Psychiatrist: | Phone: |
| Other Provider:<br>Agency: | Phone: |
| **Reason for Addiction and/or Mental Health Referral** | |
| | |

**Please Fax form to 587-473-0771 or**
**email to EDM.AMHaccess247referrals@ahs.ca**
**Questions? Contact us at 780-424-2424**