KA NI KANICHIHK INC.

Fax #: 204-953-5824

MEDICINE BEAR COUNSELLING, SUPPORT AND ELDER SERVICES

REFERRAL FORM

Referring Source/Agency: _____

Your Name and Job Title: _____

Date Referred: _____

Email address:_____

Telephone: _____ Fax: _____

Family Name of Referral: _____

Home Phone:_____ Cell # _____

Reason for Referral: Please provide as much information as possible about concerns addressed to date: _____

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Authorization For Confirmation of Receipt of Referral:

Confidentiality guidelines require a signed Release of Information form in order to confirm that this referral has been received. This means that Medicine Bear Counselling, Support & Elder Services can only provide a confirmation that this referral has been received to the referring source. The specific content of the counselling sessions will not be shared with the referring source.

_____ _____

Signature of Individual Referred Signature of Referral Source

WE WILL CONTACT THE FAMILY UPON RECEIPT OF REFERRAL