

WHO WE SERVE - REFERRAL CRITERIA

Clients must meet ALL of the following criteria in order to be seen at Arnika Centre:

- 16 Years old or over
- Full Scale IQ of 70 or below prior to age 18
- Full physical in past year
- Mental Health or Behavioural Concern
- Family Doctor Referral (if specialist referring, letter from the family doctor must accompany referral)

HOW DO I ACCESS SERVICES?

- Step 1**
 - A written referral is needed from the family doctor.
 - If a specialist is referring, a letter from the family doctor must accompany the referral indicating their support.
- Step 2**
 - When the referral is accepted, then notification is sent to the referring physician and the caregiver/client indicating the approximate wait time.
 - An intake package will be sent to the caregiver or client to be completed.
- Step 3**
 - Once the intake package is returned to the Arnika Centre, the client and/or caregiver will be notified by telephone to set-up an intake appointment.

HOW TO REACH US

- Arnika Centre is located at:
The Vocational and Rehabilitation Research Institute (VRRRI)
3304 33rd Street NW
Calgary, AB T2L 2A6
- Hours: 9:00 AM to 4:30 PM
- For more information contact:
Serena Andersen
Coordinator
Phone: 403-284-1121 (ext. 324)
Fax: 403-267-1241



PHYSICIAN REFERRAL FORM

Name: _____ Date: _____

DOB: (dd/mm/yy) _____ Sex: M F

Personal Health Number: _____

Street Address: _____

City: _____ Province: _____ Postal code: _____

Phone: _____

Contact Person: _____ Relationship to patient /agency: _____

Phone: _____ Cell: _____

Address: _____

Guardian: _____ Phone: _____

Address: _____

CRITERIA FOR REFERRAL (Please ensure client meets **ALL** the follow criteria prior to referring.)

- Full Scale IQ below 70 before age 18
- Behavioural or mental health concern
- Patient 16 years or older
- Complete physical in past year

Presenting Problem: _____

Past Medical History: _____

Medications: _____

Is this individual currently receiving Psychiatric Service? No Yes

If yes, current psychiatrist's name: _____ Date last seen: _____

Referring Physician: _____ PRACID #: _____

Address: _____

Phone: _____ Fax: _____