Centre for
Restorative
Mental Health

CRMH Referral Form

Client Information
Name:

Phone:
May a confidential voice message be left at this number? Yes No

Email:

Mailing Address:

D.O.B:

Referral Information
Referred by:

Phone:

Email:

Date of Referral:

Referral for: Individual therapy / Couples therapy / Family therapy

Is the client aware of and consenting to this referral? Yes No

Reason for Referral:

Sending referral form: If possible, please use our secure messaging feature to send confidential referral information. To access secure messaging, please email crmhinfo@gmail.com to obtain your personal sign in name and password for access to our secure messaging portal.

#3, 4825 51 St, Camrose AB T4V 1R9 780-781-8980 crmhinfo@gmail.com