

**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.

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Signature of Individual Referred

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Signature of Referral Source

**\*\*WE WILL CONTACT THE FAMILY UPON RECEIPT OF REFERRAL\*\***

