



Galia Wellness Services

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Practitioner Referral Form

Galia Wellness Services

Professional Referral Form – Psychotherapy Services

Important Notice:

Galia Wellness Services provides outpatient psychotherapy and does not offer crisis or emergency services. If the client is at immediate risk, please contact local emergency services or appropriate Northern Regional Health Authority crisis supports prior to submitting this referral. Submission of this form does not guarantee acceptance of services.

Clients will be contacted directly to complete intake and informed consent.

Referring Professional Information

Referring Professional Full Name: _____

Agency / Organization: _____

Phone Number: _____

Secure Email _____

Professional Contact (*Select only one*)

I consent to being contacted for clarification regarding this referral.

I do NOT consent to being contacted

Client Information

Client Full Name: _____

Preferred name (if applicable): _____

Date of Birth (YYYY-MM-DD): _____

Mailing Address: _____

Phone Number: _____

Voice Mail (*Select only one*)

Voicemail permitted

Voicemail NOT permitted

Emergency Contact (name & phone number): _____

Parent / Guardian Name (if under 18): _____

Parent / Guardian Phone number: _____

Consent Confirmation

Confirmation (*Select only one*)

I confirm that informed consent has been obtained from the client (or legal guardian) for this referral and the sharing of relevant clinical information with Galia Wellness Services.

Consent has NOT been obtained (Referral will be deferred until Consent is Confirmed)

Date Consent Obtained (YYYY-MM-DD): _____

Presenting Concerns

Primary Concerns (brief summary)

Relevant Diagnosis (if applicable)

Therapy Goals (if known)

Anything else the therapist should know about this client's situation?

Risk Screening

Current Risk Status (*Select only one*)

- No known risk
- Passive Suicidal Ideation
- Active Suicidal Ideation
- History of Self Harm
- Violence Risk

Safety Plan (*Select only one*)

- Safety Plan in place (copy available)
- Safety Plan NOT in place

Community Safety (*Select only one*)

- Client Safe in home community
- Community Safety unknown / uncertain

Recent hospitalizations (if applicable, past 6 months)

PLEASE NOTE

If active or imminent risk is present, referral acceptance may be deferred pending stabilization through appropriate emergency services.

Current Supports

Current Mental Health Providers

Primary Care Provider (if known)

Current Medications (if relevant)

Confirmation (*Select only one*)

I confirm the information provided is accurate to the best of my knowledge. The client has been informed that Galia Wellness Services is an outpatient psychotherapy provider and not a crisis service.

Contact requested for clarification

Practitioner Signature: _____

Date (YYYY-MM-DD): _____