



Professional Referral Form – Psychotherapy Services

| Updated October 2026

Rm 202 North Centre Mall, 3 Station Road, Thompson MB R8N 0N3
| (888) 664-6458 | carolinewinship@galiawellness.ca

> **Important Notice:** Galia Wellness Services provides outpatient psychotherapy only — no crisis or emergency services. If the client is at immediate risk, contact emergency services or Northern Regional Health Authority crisis supports **before** submitting. Submission does not guarantee acceptance. Clients will be contacted directly for intake and informed consent.

Referring Professional

Full Name	
Agency / Organization	
Phone	
Secure Email	
Preferred Contact	☐ Phone ☐ Email

Client Information

Full Name	
Preferred Name	
Date of Birth (YYYY-MM-DD)	
Community of Residence	
Phone	
Voicemail OK?	☐ Yes ☐ No
Emergency Contact (name & phone)	
Parent / Guardian (if under 18)	
Parent / Guardian Phone	

Consent Confirmation

Client has consented to this referral	☐ Yes ☐ No ☐ Guardian consent obtained
Date Consent Obtained (YYYY-MM-DD)	

Presenting Concerns

Primary Concerns (brief summary)	
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Relevant Diagnosis (if applicable)	
Therapy Goals (if known)	

Risk Screening

Current Risk Status (select all that apply)	☐ No current risk ☐ Passive SI ☐ Active SI ☐ Homicidal Ideation ☐ Self-harm ☐ Other
Safety Plan in place	☐ Yes ☐ No ☐ Unknown
Community Safety concerns	☐ Yes ☐ No ☐ Unknown
Recent Hospitalizations (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	
Current Medications (if relevant)	

Referring Professional Confirmation

I confirm the information provided is accurate to the best of my knowledge and that the client has been informed of this referral.

Signature	
Date (YYYY-MM-DD)	

*upon completion, please fax to (431) 302 - 8884
or email securely to carolinewinship@galiawellness.ca*

Thank you for your trust in Galia Wellness Services

*Caroline NJ Winship, M.Couns., CCC
Founder & Lead Psychotherapist
carolinewinship@galiawellness.ca
(431) 830 - 4545 (in Manitoba), (888) 664 - 6458 (Toll free)*

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