

# KELLY MENTAL HEALTH

— Always Getting Better —

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## Referral Form

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Client Name: \_\_\_\_\_

Date of Birth (YYYY/MM/DD): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

Primary Contact:  Client  Other: \_\_\_\_\_

Status #: (if applicable) (10 digits) \_\_\_\_\_

### Indian Residential School (IRS) – Resolution Health Support Plan

Former attendees and their family members may be eligible for extended benefits for counselling services.

Name of Attendee: \_\_\_\_\_ Relation: \_\_\_\_\_

Attendee's Date of Birth: \_\_\_\_\_ Status Number: \_\_\_\_\_

### REASON(S) FOR REFERRAL:

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REFERRED BY: \_\_\_\_\_

Referrer's Preferred Contact: Phone | Email | Fax

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**How would you like to receive  
appointment confirmations? (circle one)**

**Email or Text Message**

*Appointment Confirmations are provided 2  
business days before each session.*

*Please ensure we have your up-to-date  
contact information*