



Registered Psychotherapy & Mental Health Support
EMPOWERING YOU TO HEAL AND GROW

PSYCHOTHERAPY REFERRAL FORM

Assessment & Treatment

REFERRING PHYSICIAN OR NURSE PRACTITIONER INFORMATION

First Name: _____ Last Name: _____

Area of Specialization: _____

Contact Information

Address: _____

City: _____ Province: _____

Postal Code: _____ Phone: (____) _____

Organization/Agency (if applicable): _____

Reason(s) for Referral & Additional Details (Please specify):

- PTSD (Post Traumatic Stress Disorder) Anxiety Panic Disorder Depression / Low Mood
 Adjustment Disorders Other (Please specify):

Comment:

Is the client aware of this referral? Yes No

Date of Referral: (MM/DD/YYYY) _____ Signature _____

CLIENT INFORMATION

First Name: _____ Last Name: _____

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

Address: _____ City: _____ Province: _____

Postal Code: _____ Phone: (____) _____ Email: _____

All information shared is strictly confidential in accordance with professional and ethical standards of practice.