*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:** ______________________

**Provider No. (PHN)** ______________________ **CPSO License No.** ______________________

**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.*

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