

Choose one of the following:

Option 1

**Attach Patient Label**

**Urgency**

Routine

Urgent (please provide reason under Additional Information)

Date of referral:

Option 2 - Leave blank if above complete

**Patient Information**

Patient Last Name:

DOB:  Patient Phone:  Patient Email:

Address:

City:  Province:  Postal Code:

**Referring Provider Information**

Clinician Name:  Clinic / Facility Name:

Phone Number:  Email:  Practice ID:

Address:

City:  Province:  Postal Code:

**Requested Services**

Please complete the requested service checkboxes on page 2.

Use Additional Information to provide referral context, urgency details, or relevant history.

Preferred contact method:  Email:

Alternate Contact:  Date:



### 1. Counselling Services

- Anxiety Therapy
- Depression Therapy
- EMDR Therapy
- PTSD and Trauma Treatment
- Parenting Coaching
- OCD Therapy
- Couples Counselling
- Sports Psychology
- Chronic Illness & Pain
- Bipolar I & II Counselling
- Infertility Counselling

### 2. Assessment Services

- ADHD Assessments
- Psychoeducational Assessments
- Personality Assessments
- Parenting Assessments
- PTSD Assessments
- Relationship Assessments
- Autism Spectrum Disorder & Neurodevelopmental Assessments
- Forensic Psychological Assessments

### 3. Workshops

- Mental Well-Being for Athletes & Teams
- Mental Well-Being in the Workplace
- Mindful Sport Parenting Workshop
- Workshop For Teachers

### Additional Information & Concerns

Include reason for urgency, presenting concerns, relevant history, and any referral notes.

