

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. Assessment Services

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

2. 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

3. Neurostimulation / Brain Based Treatment

- rTMS

4. 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.

