TORONTO PSYCHOLOGY CLINIC

Referral Form

Thank you for referring to the Toronto Psychology Clinic. Please complete all of the below fields and our Intake Coordinator will contact the patient to schedule an appointment.

Referring Professional's Information

Name of Referring Professional:_____

Speciality of Referring professional:_____

Name of Clinic or Organization:_____

Address:_____

Phone number: _____

Fax number:_____

Client Information

Please complete all the information you have for this patient at this time:

Name: _____

Date of birth: _____

Cell Phone number: _____

Home Phone Number:_____

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Work Phone Number:_____

Do we have permission to leave voicemail? Yes ___ No ____

Email address: _____

Do we have permission to email the client? Yes ___ No ___

Referral date:_____

Reason for referral:

_____

_____

_____

Current Medications:_____

Please send completed form to our confidential fax at 416-551-2183

123 Edward Street, Suite 1103, Toronto, ON, M5G 1E2 **t**: 416.551.1759 **f**: 416.551.2183 **e**:info@torontopsychology.com