Patient Referral Form

Date of referral _____

Fax completed form to 1 289 203-1178

Patient information

Last name _____ First name _____

DOB (mm/dd/yyyy) _____

Patient's email address * _____
(if known)

Patient's phone # _____

Can we leave a message on patient's voicemail? ☐ Yes ☐ No

* Client will be contacted via email to arrange initial appointment

Reason for referral

- ☐ Anxiety
- ☐ Anger
- ☐ Eating Disorders
- ☐ Depression
- ☐ Stress
- ☐ Relationships
- ☐ Insomnia
- ☐ Phobias
- ☐ Trauma / PTSD
- ☐ OCD
- ☐ Substance Abuse
- ☐ Other _____

Referring physician

Referring physician comments

Please include any current medications

If you have any questions about the referral process, please contact us:

info@telecbt.ca

www.telecbt.ca

DISCLAIMER: TeleCBT is not appropriate for crisis counseling.