



# 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

## Appointment details

Time zone  PT  MT  CST  CDT  ET  AT  NT

Preferred Appointment time  Weekday  Weekend  
 Morning  Afternoon  Evening

## Reason for referral

- Anxiety
- Depression
- Insomnia
- OCD
- Other \_\_\_\_\_
- Anger
- Stress
- Phobias
- Chronic Pain
- Eating Disorders
- Relationships
- Trauma / PTSD
- Substance Abuse

## Referring physician

Blank space for referring physician information.

## Referring physician comments

Blank space for referring physician comments.

**Convenient, confidential online counseling. We can help.**

If you have questions, please contact us:  [info@telecbt.ca](mailto:info@telecbt.ca)  [www.telecbt.ca](http://www.telecbt.ca)



*DISCLAIMER: TeleCBT is not appropriate for crisis counseling.*