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

Referring physician

Referring physician comments

Convenient, confidential online counseling. We can help.

If you have questions, please contact us: info@telecbt.ca www.telecbt.ca

DISCLAIMER: TeleCBT is not appropriate for crisis counseling.