Psychology Clinic | Department of Psychology | University of Victoria
Cornett building room A163 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
P: 250-721-7538 | F: 250-472-5319 | E: psyclin@uvic.ca | W: uvic.ca/psychologyclinic

Client Therapy Referral Form

Date of Referral: _____

Name of Client: _____ Date of Birth: _____

Address: _____

City/Postal code: _____

Phone number: _____ Okay to leave message? (Y/N) _____

Alternate Phone: _____ Okay to leave message? (Y/N) _____

Email: _____ Do you self-identify as Indigenous? (Y/N) _____

Referral Source: _____
Phone: _____
FAX: _____
Address: _____
City/Postal Code: _____

Client informed of referral? (Y/N) _____
Client informed of fee **- $125 per session?** (Y/N) _____

Client's Physician (if different from Referral Source above): _____
Telephone: _____ FAX: _____

Specialist (if involved): _____ Telephone: _____ FAX: _____

Reason for referral for therapy: _____
_____
_____
_____
_____
_____

Are you currently experiencing suicidal thoughts? (Y/N) _____

Previous therapy experience: _____
_____
_____
_____

Supporting documents sent with referral include: _____
_____
_____

How did you hear about us? _____