Psychology Clinic | Department of Psychology | University of Victoria
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Client Psychoeducational Assessment Referral Form

Referral Date: (dd/mmm/yyyy): _____

Name of Client: _____ Date of Birth (dd/mmm/yyyy): _____

Address/City: _____ Postal Code_____

Phone #: _____ Alternate Phone #: _____ Email: _____

If client is a child (under 19 years of age) or under guardianship, please provide:
Name of parent or guardian: _____ Contact #: _____
Name of contact person (if different from above): _____ Contact #: _____

Referral Source (if self-referring, indicate 'SELF' _____

Phone: _____

FAX: _____

Address/City: _____

Postal Code: _____

Client informed of referral? (Yes/No) _____
Client informed of fee - $2500? (Yes/No) _____

Client's Physician (if different from Referral Source above): _____
Phone: _____ FAX: _____
Specialist (if involved): _____ Phone: _____ FAX: _____

Referral Question: (clearly state goal of assessment and areas of functioning that require assessment)

_____
_____
_____

Previous assessments: (provide date & place, attach copy of reports)

_____
_____

Patient medical and birth development history: (including current medications) *If referral is for a child, has hearing and vision been thoroughly assessed? Our assessment may require this to be done before testing occurs.

_____
_____
_____

Family Medical History:

_____
_____

Please attach previous assessment records, medical reports, school records