Psychology Clinic | Department of Psychology | University of Victoria
Cornett building room A163 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
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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: Healthcare provider (if self-referral, put 'SELF'): _____

Phone: _____
FAX: _____
Address: _____
City/Postal Code: _____
Client informed of referral? (Y/N) _____

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

Are you currently involved in any legal matter or ongoing litigation? (Y/N) _____

Reason for therapy referral: _____
_____
_____
_____
_____
_____

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

Previous therapy experience: _____
_____
_____
_____

Supporting documents sent with referral include: _____
_____

How did you hear about us? _____