

Referral from Physicians

Scarborough Psychotherapy Services

11721 Sheppard Ave. E. Scarborough ON M1B 1G3

Phone: 289-806-8981

Email: info@scarboroughpsychotherapy.ca

Website: www.scarboroughpsychotherapy.ca

Note: A doctor's referral and/or letter is not required for patients to access services at Scarborough Psychotherapy Services. For a patient under 18, this form should only be completed and submitted with the consent of the youth and/or parent/guardian.

IMPORTANT: CHECK HERE IF YOUTH PROVIDED CONSENT TO REFERRAL AND WOULD LIKE SUPPORT TO REMAIN CONFIDENTIAL FROM CAREGIVERS ☐

REFERRAL SOURCE

Name of Referring Physician/Professional: _____

Referral Email Address: _____

Referring Agency/Clinic: _____

Referral Phone Number: _____

Referral Fax Number: _____

PATIENT INFORMATION

Name of individual(s) requiring services: _____

If patient is UNDER 18, please provide parent/guardian's full name:

Patient's Date of Birth: _____

Phone number (or parent/legal guardian's number if client is UNDER 18):

Email address (or parent/legal guardian's email address if client is UNDER 18):



TYPE OF SERVICE REQUIRED (CHECK ALL THAT APPLY)

- ☐ Child and adolescent therapy (ages 6-17)
- ☐ Individual therapy (18+)
- ☐ Family therapy
- ☐ Couples therapy
- ☐ Eating disorder therapy
- ☐ Art therapy

Please provide a brief history or reason for referral. Please identify primary concerns and diagnoses and comorbidities/ co-factors (if applicable):

Are there current court/medical legal and/or custody matters that you are aware of?

Does the patient need an interpreter? If yes, what language?

Who is consenting to treatment or assessment for this referral?

Please attach any relevant information (e.g., Past Medical History, Medication list/Allergies, Test results (e.g., MMSE, imaging results), and/or relevant consultation reports from other professionals).

Referrals can be emailed to info@scarboroughpsychotherapy.ca

Thank you for your referral