University of Victoria

Psychology Clinic | Department of Psychology
Cornett Building Room A163 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-721-7538 | F 250-472-5319 | mailto:psyclin@uvic.ca| uvic.ca/psychologyclinic

Client Therapy Referral Form

Date of Referral: _____

Name of Client: _____ Date of Birth: _____

Address: _____

City/Postal code: _____

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

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

Email: _____

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

Client informed of referral? (Y/N) _____
Client informed of fee? (Y/N) _____

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

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

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

Previous therapy experience: _____
_____
_____
_____

Supporting documents sent with referral include: _____
_____
_____
_____