



PSYCHOLOGICAL

Referral / Request for Psychological Services

For self-referrals and referrals from physicians, psychiatrists, and other professionals.

1. REFERRAL SOURCE

Who is completing this form? ☐ Self ☐ Parent/guardian ☐ Physician/psychiatrist

☐ Other health professional ☐ Other

Referrer name / organization: _____

Profession / role (if applicable): _____ **Phone:** _____

Email: _____ **Fax:** _____

If referring someone else: ☐ The client knows about and agrees to this referral.

☐ Please contact me before contacting the client.

2. CLIENT INFORMATION

Client name: _____ **Date of birth:** _____

Pronouns (optional): _____ **Preferred name:** _____

Phone: _____ **Email:** _____

Preferred contact: ☐ Phone ☐ Voicemail ☐ Text ☐ Email

May we identify Refine Psychological when contacting you? ☐ Yes ☐ No

If client is a minor, parent/guardian name(s): _____

3. SERVICES REQUESTED

Select all that apply:

☐ Individual therapy - adult ☐ Individual therapy - teen ☐ Child therapy

☐ Couples therapy ☐ Family therapy ☐ Psychological assessment

☐ Parent consultation ☐ Other: _____

Preferred format: ☐ In person ☐ Virtual ☐ Either **Preferred clinician:** _____

Scheduling needs / availability: _____

4. REASON FOR REFERRAL / PRESENTING CONCERNS

Please describe the main concerns and what the client hopes will be different:

How long have these concerns been present? _____

Relevant diagnoses, health concerns, medications, or previous treatment (optional):

4. REASON FOR REFERRAL / PRESENTING CONCERNS (CONTINUED)

For professional referrers: What would you like psychology to assess, address, or support?

5. CURRENT RISK / URGENCY

Are there any current safety concerns?

☐ No ☐ Yes ☐ Unsure

If yes or unsure, describe the concern and any support currently in place:

Referrals are not monitored for crisis response. For immediate danger or a need for same-day assessment, call 911 or go to an emergency department. For suicide crisis, call or text 988.

6. CLINICIAN MATCHING / ACCESS NEEDS

Preferences that would help us find a good fit (optional): clinician gender, language, cultural considerations, areas of expertise, accessibility needs, etc.

Insurance / funding (optional):

☐ Private insurance ☐ WCB ☐ Motor vehicle insurer

☐ Other: _____

7. ADDITIONAL INFORMATION / DOCUMENTS

Relevant records may be attached with appropriate authorization. Please send only information reasonably necessary for this referral.

Documents attached:

☐ None ☐ Medication list ☐ Assessment/report

☐ Other: _____

8. CONSENT & CONTACT

By submitting this form, I confirm that the information is accurate to the best of my knowledge.

If referring another person, I confirm that I have appropriate authority or consent to provide this information and request contact, unless otherwise noted above.

Name: _____

Date: _____

Signature (PDF / paper referrals): _____

SUBMISSION

Completed forms may be faxed to 780-752-7271.

Please avoid sending sensitive health information by ordinary email.