Lifespan Behavioural Health Inc.

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Referral Form for Psychological Services

Name of the individual and/or organization completing this form:

_____

Your Contact email and phone: _____

What is your relationship to the Client:

Medical Professional ☐ Parent/Legal Guardian ☐ School Staff☐ The Ministry Staff ☐
Self ☐
Other (please specify): _____

Client Information

Full Name:	_____
Date of Birth (YYYY-MM-DD):	_____
Parent/Guardian Name (if client is a child):	_____
Phone Number:	_____
Email:	_____

Service Requested (please select):

Psychological Assessment ☐ Psychotherapy ☐

Other (please specify): _____

We will contact the client and/or their family directly within two business days of receiving this form.