BALBODHI WELLNESS
COUNSELLING & PSYCHOTHERAPY

REFERRAL FORM

REFERRING PROFESSIONAL	
Name (First & Last)	Date
Profession/Speciality	Phone Number
Email	Fax Number

PATIENT/CLIENT DETAILS		
First Name	Last Name	Date of Birth (mm/dd/yyyy)
Phone Number	Email	
Relevant Symptoms/Diagnoses		
Reason for Referral		
Additional Details (e.g. preferred name, gender/pronouns, past history, etc.)		

Signed Consent to Release Personal Health Information Attached	Yes ☐	No ☐
Additional Medical Records/Assessments Attached	Yes ☐	No ☐
Can a confidential message be left at the patient's phone number?	Yes ☐	No ☐

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