TODAY'S DATE:_____

REFERRAL WAS RECEIVED BY:

☐ EMAIL
☐ PHONE
☐ IN PERSON

FEES
PLEASE CALL THE OFFICE FOR PRICE LIST.

CLIENT'S INFORMATION

Name: _____

Date of Birth: _____ / ____ / ____ (d/m/yy) **Age**: _____
Sex: ☐M ☐F ☐Other

SPOUSE/PARTNER

Name: _____

Date of Birth: _____ / ____ / ____ (d/m/yy) **Age**: _____
Children/age:_____
Sex: ☐M ☐F ☐Other

CHILDREN INFORMATION

Children's ages: _____

MARITAL STATUS

☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Address:_____

City: _____ Postal **Code**: _____

Cell: _____

Email:_____

CLIENT'S CONSENT

Can information be sent to the above address/email? ☐ No ☐ Yes
Can a confidential message be left on voicemail? ☐ No ☐ Yes
Are you aware and agreeable to this referral? ☐ No ☐ Yes
Are you agreeable to receiving ATA newsletters/upcoming events/promotional materials ☐ No ☐ Yes

Insurance coverage

☐ Social Work ☐ Psychotherapy ☐ Psychology ☐ None

REFERED BY

☐ Family Physician _____
☐ Social Worker/Community Worker_____
☐ Psychiatrist/MD/Psychologist_____
☐ EAP Sponsor_____
☐ EAP Sessions_____ Certificate #_____
☐ Other (specify) _____

REFERRAL TEL:_____

REASON FOR REFERRAL

☐ Relationships/Marital ☐ Substance abuse and Addictions
☐ Depression/Anxiety ☐ Psychosis ☐ Sexual related
☐ Domestic ☐ Anger ☐ Abuse
☐ Bereavement/Grieving ☐Parenting ☐ Mentorship
☐ Psychoeducation ☐ Psychosocial ☐ Trauma
☐ Work related

_____
_____
_____
_____
_____
_____

RISK

History to Suicide Ideations/Homicide ideations
Dates: _____ ☐ No ☐ Yes
History to self-harm
Dates: _____ ☐ No ☐ Yes
Hospitalizations for mental health/Addictions
Dates: _____ ☐ No ☐ Yes
Legal Issues: assault, criminal charges
Dates: _____ ☐ No ☐ Yes
Violence/Abusive
Dates: _____ ☐ No ☐ Yes
Alcohol, Illicit drugs, cannabis, recreational drugs use

_____
_____

Formal Mental Health diagnosis

_____
_____

Mental health medications

_____
_____

PLEASE BE REMINDED WE NEED 24 HOURS NOTICE FOR CANCELLATION OF SCHEDULED APPOINTMENTS

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