

PSYCHOLOGY CONSULTATION REQUEST

Date: _____

Patient: _____

Sex: _____

Address: _____

Phone: _____

Email: _____

D.O.B: _____

Child Psychologist

Dietitian

Clinical Therapist

Adult Psychologist

Social Worker

Neuropsychologist

Clinician Requested: _____

Mood Disorder

Short Term Disability

Self Esteem Issues

Anxiety Disorder

Long Term Disability

Relationship Issues

Eating Disorder

ADHD

Anger Mgt.

Chronic Pain

Behavior Mgt.

Trauma/ Grief and Loss

Parenting Skills

Psychoeducational Assessment

Neuropsychological assessment

Smoking Cessation

Addictions

Pertinent Clinical Information:

Signature: _____

Referring Practitioner: _____

The Therapy Centre
2525 Old Bronte Road
Suite 330 Oakville, ON