Neuropsychological Assessment Intake Referral Form

Please fax/email referral and related documents to:
FAX: (289) 291-0207
EMAIL: info@thetherapycentre.ca

You can also call our office directly and complete the referral by **PHONE: (289) 291-0205.**

Client Information:
Name of Client (Last Name/ First Name):
Date of Birth (dd/mm/yyyy):
Gender:
Address:
Email:
Telephone:
Preferred Language:
Interpreter required?

Family Physician:
Name of Family MD:
Last Assessment Date:
Practice:
Address:
Tel/Fax:
Email:

Intake Information:

INSTRUCTIONS: Please provide a brief history or reason for referral including specific concerns and/or specific questions you wish to be addressed. Please identify primary concerns and comorbidities (if applicable):

Primary Concern:

Active co-morbidities/co-factors:

Please attach any relevant information (e.g., Past Medical History, Medication list/Allergies, Test results (e.g., MMSE, imaging results), and/or relevant consultation reports).

Referral Source Information:
***Please note a doctor's referral is *not* required**
Name:
Telephone:
Fax:
Date of Referral: