IG Vital Health – Psychotherapy Services

Tel: 416-520-6910 Fax: 416-352-5926

PSYCHOTHERAPY PATIENT REFERRAL FORM

Patient's Name_____________________________________

Patient's Contact Number____________________________

Diagnosis & Additional Details (Please specify):

❑Depression

❑Anxiety

❑PTSD (Post-Traumatic Stress Disorder)

❑Adjustment Disorder

❑Other (Please specify the *diagnosis**): ____________________________________

Comments:

Referring Practitioner_______________________________

Contact Information__________________________________

Referral Date_______________________________________

Signature____