

# Psychotherapy Referral Form



Freemont Clinic

Psychotherapy Referral Form

**Fax: (647) 930-3569**

**Phone: (416) 560-3675**

**Email: freemontclinic@hotmail.com**

**Website: freemontclinic.com**

---

## Patient Information

Patient's Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

UCI – Insurance Number: \_\_\_\_\_

---

## Diagnosis & Additional Details (Please specify)

☐ Anxiety

☐ Depression

☐ Stress

☐ Trauma and PTSD

☐ Relationship Issues

☐ Life Transitions

☐ Mood Disorders

☐ Family Conflict

☐ Anger Management

☐ Others (please specify): \_\_\_\_\_

---

## Comments

---

## Referrer Information

Referring Practitioner: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Referral Date: \_\_\_\_\_

Signature: \_\_\_\_\_