Burlington Psychology

Psychological Counselling & Assessment Services

REFERRAL FORM

Patient name: ____ ☐ Male ☐ Female

Date of Birth: ____

Address: ____

____

Tel: ____

Referral: ☐ Self ☐ Other

Name: ____

Practice/
Institution: ____

Tel: ____

Fax: ____

Reason for Referral: ☐ Treatment ☐ Assessment ☐ Medical-Legal Assessment

☐ Other ____

Comments:

____ ____
Signature Date

Please return this form via Fax: (289) 635-2506 or
Email: info@burlingtonpsychology.ca
Attn: Dr. James Hutchinson

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