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_____