



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)

Panic Disorder

Adjustment Disorder

Other (Please specify the *DSM-5 diagnosis**): _____

Comments:

Referring Physician (MD/NP) _____

Contact Information _____

Referral Date _____

Signature _____

www.igvitalhealth.com

Member agency - service provider:

