Referral Form

Thank you for your referral. MentalOptimist provides and develops a care plan including assessment and treatment as appropriate for your patients. For questions, please call 1-647-921-7124 from 9:00am - 7:00pm, Monday to Saturday.

Please print or complete electronically and fax to 1-647-480-0980 or email to Mentaloptimist@gmail.com

Date of Referral:

Therapist: Choose From Therapists _____

Client Full Name_____ DOB: _____

Address _____ City _____ Postal Code _____

Phone: Cell _____ Home: _____

☐ The patient or lawfully authorized substitute decision maker has consented to this referral

Referral Services Requested:

- ☐ Counselling for Refugees
- ☐ Counselling for New-Comers
- ☐ Individual Counselling
- ☐ Marriage Counselling
- ☐ Family Counselling
- ☐ Couple Counselling
- ☐ Child and Adolescent Counselling
- ☐ Addiction Counselling
- ☐ Forensic Counselling
- ☐ Motor Vehicle Accident

Reason for Seeking Services:

- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

Does the Client Require a Translator? Yes No

If yes, language _____

Mental Optimist

Referring Organization: _____

Type of Organization: Family Doctor Psychiatrist Lawyer

Other Organization: _____

Address: ……

Signature: _____ Date: _____