Aks Counselling and Psychotherapy Services
55 Village Centre Pl, Suite 200,
Mississauga, ON L4Z 1V9
P: +1(647)-291-8045
F: 289-819-6555
E: info@akstherapy.ca
W: https://www.akstherapy.ca

COUNSELLING AND PSYCHOTHREAPY REFERRAL FORM

Date of Referral: ___/___/____ (please use DD-MM-YYYY format for all dates in the form)

Is the client aware of and agreeable to this referral? ☐Yes ☐No

CLIENT INFORMATION

Name: _____ DOB: ___/____/_____ Age: ____

Pronouns: _____ Parents/Guardian (if under 18 y/o): _____

Address: _____

_____

Home Phone: _____ Mobile Phone: _____

Allowed to identify service and leave a message? ☐Yes ☐No

E-mail: _____ Allowed to send email? * ☐Yes ☐No

*Note: Email is not considered a confidential medium of communication

Insurance Coverage: ☐Yes ☐No

ADDITIONAL INFORMATION (DIAGNOSES, MEDICATIONS, ETC.)

REFERRING PROFESSIONAL

Name/Organization: _____

Phone: _____ Fax: _____

Signature: _____

PLEASE SEND THE REFERRAL VIA FAX TO 289-819-6555
OR VIA EMAIL TO INFO@AKSTHERAPY.CA