INSIGHT Psychological™

FILE NUMBER
(For Insight Use)

REFERRED BY:

Name: _____

Date _____

Phone #: _____

Fax: _____

Email: _____

Signature: _____

CLIENT'S INFORMATION:

Client: _____
Last Name, First Name
Gender _____

Primary Phone #: _____

E-mail: _____

Address: _____

Health Insurance # _____

PROVIDE A BRIEF EXPLANATION OF THE CLIENT'S MEDICAL HISTORY:

PROVIDE ANY CURRENT MEDICATIONS CLIENT MAY BE USING:

REASON FOR REFERRAL:

ADDITIONAL COMMENTS:

Special Provisions for Clients: Please note that Insight Psychological is a private fee for service clinic. There may also be special provisions that Insight has arranged for clients. Such would be specified in the Memorandum of Understanding that Insight has established. We thank you in advance for honoring those provisions.

Referral Name: _____ and E-mail: _____

Please forward this referral form and consent to release information to: referrals@insightpsychological.ca

Please note that we will attempt to contact the client within 48 hours of receiving this referral. If we are unable to reach the client after three (3) attempts over several days, we will close the referral and notify the referring party. A new referral can be submitted should the client wish to be re-contacted for service. Note that clients are also welcome to reach out to our offices independently.

CLIENT CONSENT TO RELEASE PERSONAL INFORMATION

I, _____(name of client), hereby authorize _____ (referring party/organization) to release my name and any applicable information, and/or that of my minor child(ren), whichever is applicable to Insight Psychological Inc. for the purpose of facilitating a referral and arranging services offered by Insight Psychological Inc.

I understand that the information shared may include personal and/or treatment-related details necessary for Insight Psychological Inc. to assess my/my child(ren)'s needs and contact me to arrange services.

I also consent to Insight Psychological Inc. contacting me via phone call or email for the purpose of discussing care, treatment, or administrative matters related to this referral.

I understand that this consent applies only to the release of information necessary for the referral and service arrangement process. I further understand that the information released by this consent cannot be shared with any other party for any other purpose unless I provide written permission to do so.

My signature indicates that I have read this form and/or it has been explained to me in a language that I understand. This consent form expires one (1) year from the current date undersigned, unless revoked by me in writing prior to that date.

_____ _____

Print name of Client/Parent/Guardian Print name of Witness

_____ _____

Signature of Client/Parent/Guardian Signature of Witness

CLIENT CONTACT INFO:

Phone Number: _____

E-Mail: _____