



Welcome to Insight Psychological!

At Insight, we have compassionate and experienced therapists offering therapy on many issues. Working together with your therapist, you will be able to identify goals for counselling and to evaluate your progress towards these goals.

## Patient Referral Form

### PATIENT'S PERSONAL INFORMATION:

Patient: \_\_\_\_\_  
Last Name First Name

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Primary Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

### REASON FOR REFERRAL AND ANY ADDITIONAL INFORMATION:

Type of Service Requested:  Counselling  Assessment  Other, specify: \_\_\_\_\_

Type of Counselling:  Individual  Couple  Family

Preferred Service Location:  Edm South  Edm North  Edm Central  Edm West  
 Sherwood Park  Calgary  Online

Referred by: \_\_\_\_\_  
Name & Title Phone # Date (MM/DD/YYYY)



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**CONSENT FOR OBTAINING AND RELEASE OF CONFIDENTIAL INFORMATION**

I \_\_\_\_\_ (Please print name & relationship to client {if not the client}) hereby authorize the staff at **INSIGHT PSYCHOLOGICAL Inc.** to:

Obtain information from \_\_\_\_\_

Release information to \_\_\_\_\_

*Third party information (doctor, lawyer, adjuster, etc.):*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The purpose(s) of releasing information (include reason and/or select options below):

Progress \_\_\_\_\_ Evaluation / Testing results \_\_\_\_\_ Diagnosis \_\_\_\_\_

I understand that I give consent concerning information, which by law may be considered confidential or privileged. I understand that the information released by this consent cannot be released to anyone else unless I give written permission.

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 Counselor/Witness

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Signature of Counselor/Witness

Dated \_\_\_\_\_

Dated \_\_\_\_\_