(705) 783-4676
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REFERRAL FORM

*****FOR USE BY REFERRING PROFESSIONALS ONLY*****

NAME *(First, Initial, Last)*		
DATE OF REFERRAL *(m/d/y)*	**DATE OF BIRTH** *(m/d/y)*	**GENDER**
MAILING ADDRESS		
PARENT/GUARDIAN NAME(S) ☐ **DO NOT CONTACT PARENT/GUARDIAN** *(Option only if 12 years or older)*	**HOME**	☐ **yes, leave messages**
	WORK	☐ **yes, leave messages**
	CELL	☐ **yes, leave messages**
EMAIL *(Provide only if checked regularly)*	**EMERGENCY CONTACT** *(if different from above)*	

NAME OF REFERRING PROFESSIONAL	
PLACE OF BUSINESS	**PHONE/EXTENSION**
	SIGNATURE

REASON FOR REFERRAL:

CURRENT DIAGNOSIS, MEDICATIONS:

OTHER INFORMATION:

CHILDREN UNDER 12 YEARS OF AGE REQUIRE SIGNED PARENT/GUARDIAN CONSENT

Youth or Parent/Guardian Printed Name **Signature** **Date** *(m/d/y)*