Psychotherapy – Referral Form
24 Hour Response TIme
Online Form – www.solutionfirst.ca/docform
Fax # 289-246-1851

Patient Name:

Email (if preferred):

Phone:

Primary Care Provider:

Patient experiencing (Optional):

- ☐ Addiction
- ☐ ADHD
- ☐ Anger
- ☐ Anxiety
- ☐ Behavioural Issues
- ☐ Burnout / Work Stress
- ☐ Confidence & Self Esteem
- ☐ Communication Problems
- ☐ Depression
- ☐ Emotional Regulation
- ☐ Grief & Loss
- ☐ Life Transitions / Changes
- ☐ Relationship Issues
- ☐ School Problems
- ☐ Stress
- ☐ Trauma / PTSD
- ☐ Other:

  _____

Additional Notes (optional):

Patient provided permission for SolutionFirst Therapy Clinic to contact them via:

- ☐ Phone (call)
- ☐ Email
- ☐ Text

Contact SolutionFirst Therapy Clinic
E: hello@solutionfirst.ca
P: 647-765-5624