Halle H. Sailer R.P., CACBT (M.D. in Germany)
Registered psychotherapist in Ontario (CRPO) – 004706
Canadian Association of Cognitive Behavioral Therapy

Adults, Family Therapy and Couple Therapy

#1300 Don Mills Rd., Suite 105; Toronto, Ontario, M3B 2W6 Tel: 416 737 8775 Fax: 647 350 6066

Referral Form for CBT-Therapy for Adults

Please fax to: 647 350 6066

Facilitator: Halle Sailer

REFERRAL SOURCE INFORMATION	**Date:**
Name of the referring doctor:	Physician#
Tel. number:	
Fax. number:	
PATIENT INFORMATION: PLEASE PRINT	
Last Name of Patient:	First Name of Patient:
Date of Birth:	Age: Male/Female:
Email of Patient:	Expire Date:
Cell/tel. (preferred):	Home/tel.:
Address:	Is patient aware of the referral? Which tel. number is preferred for messages? ☐ father's cell ☐ mother's cell
Reasons for Referral: Please indicate	**List of the Medication patient is currently on:** 1. 2. 3.

An appointment is scheduled for above patient on: _____at: _____
Please ask the parent to call our office to confirm or reschedule this appointment.

Please notify your patient that in the event of 'no-shows' and 'failure to cancel/reschedule with a three business days' notice', a fee of $150 will be charged.