



**Toy Box Counselling
Limited**
**202 Maple Street,
Wolseley SK**
306 450-9070
darilyn@toyboxcounselling.com

Professional Referral for Services

Referring Professional: _____ Doctor _____ SST _____ Principal _____ other

Your name: _____

Contact info: _____

Child's full name: _____

DOB: _____ Grade: _____

Reason for Referral:

_____ Anxiety

_____ Depression

_____ Withdrawal/Isolation

_____ Emotional dysregulation

_____ Learning difficulties (specify): _____

_____ Trauma (specify): _____

_____ Social skill deficit

_____ Neurodiversity Support: _____ ADHD _____ ASD _____ other

(Specify): _____

Urgency: _____ Low _____ Moderate _____ High

Comments: _____

Parents: submit this form with your application for services via email.