



## External Referral Form

### Client Information:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian (if applicable): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

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### Referral Reason (Check all that apply):

Psychotherapy  Psychological Testing  Other (please specify): \_\_\_\_\_

### Presenting Concerns (Check all that apply):

Anxiety  Depression  ADHD/Behavioral Concerns  Autism Spectrum Concerns

Trauma/PTSD  Academic Difficulties  Family Conflict  Other: \_\_\_\_\_

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### Consent for Contact and Scheduling

I, \_\_\_\_\_ (client/guardian name), authorize Agius Psychology to contact me at the provided phone number and/or email to schedule an appointment and discuss any necessary intake procedures. I understand that this does not guarantee services and that an initial assessment will determine the appropriateness of care.

I authorize voicemail messages to be left regarding appointment scheduling.

I authorize email communication regarding scheduling.

I authorize communication between Tiny Steps and the referral source below for scheduling purposes only (additional consents may be signed after intake for further communication)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### Referral Submission:

Referring Organization: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

Email: \_\_\_\_\_

Please send completed referral forms via email [info@agiuspsych.ca](mailto:info@agiuspsych.ca) or fax (818) 666-0221

For any questions, please contact our office at (647) 699-6089.

Thank you for your referral!