ADVANCE HEALTH
Psychotherapy and Psychological Services
1200 Bay Street, Suite 300
Toronto ON M5R 2A5
Email: reception@advancehealth.ca
Voice: 416-849-4776

FAX COMPLETED FORM TO 416-849-4778

- **We will make three attempts** to reach the client within one week of receiving the referral.
- **We will notify you** when your client has been scheduled or if we are unable to reach them.

Referral Source Name: _____.

Tell Us Who You Are:

- ☐ Family Doctor
- ☐ Other Healthcare Provider / Specialist
- ☐ WSIB Case Manager
- ☐ Other: _____ .
- ☐ HR / Union Rep / Supervisor / Employer
- ☐ Teacher/School Counsellor
- ☐ Legal Rep

Referral Source Email: _____.

Referral Source Phone Number: _____. Referral Source Fax Number: _____.

Client Referral Information

First name: _____. Last name: _____.

Client Date of Birth (Month/Day/Year): _____.

Client Email: _____. Client Telephone Number: _____.

Insurance Company/WSIB Claim Number _____.

Presenting Concern / Reason for Referral:
If client is a MINOR, provide as much guardian information as you can (NAME/PHONE/EMAIL/ADDRESS):