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Referral Form

Client Information *(Please fill all requested information)*	
Name: DOB: Address: Phone #: Email: Date of Referral: (If using NIHB Benefits) Status Card#:	
○ **Virtual Therapy (Email Required)**	○ **In-Person Therapy**

Areas of Concern (Select all that applies)	
○ Trauma	○ Grief
○ Intergenerational Trauma	○ Addictions Counselling
○ Harm Reduction Counselling	○ Interpersonal Relationships
Other (Please specify:	

Referring Agency Contact	
Name: Position:	Contact: Extension: E-mail:

Referring Agency Signature **Date**

Please Scan and Return Referral File to ***info@patchampagne.com***