## Dr. Sharma Psychological Services Referral Form

**(please print this form, complete and fax to 905-232-0610)**

**Date:** ______________________________________________

**Referral Source Information:**

**Contact Person:**__________________________**Company Name:**______________________________

**Address:**____________________________________________________________________________

**Telephone:**___________________________________**Fax:**___________________________________

**E-mail Address:**_______________________________________________________________________

**Client Information:**

**Name:**______________________________________________________________________________

**Address:**____________________________________________________________________________

**Home Phone:**______________________________**Cell:**_______________________________________

**Date Of Birth:**_____________________**E-mail Address:**_____________________________________

**Reason For Referral:**__________________________________________________________________

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**Family Physician:**

**Name:**______________________________________________________________________________

**Address:**____________________________________________________________________________

**Telephone:**________________________________**Fax:**______________________________________

**Legal Representative:**

**Name:**______________________________________________________________________________

**Address:**____________________________________________________________________________

**Phone:**___________________________________**Fax:**_______________________________________

**If this is an MVA case, please provide automobile insurance information:**

**Adjuster Name:**_______________________________________________________________________

**Insurance Company:**____________________________________________________________________

**Address:**____________________________________________________________________________

**Telephone:**___________________________________**Fax:**___________________________________

**Policy Number:**_____________________________**Claim Number:**____________________________

**If this is a WSIB case, please provide WSIB information:**

**Adjudicator/Case Manager Name:**___________________________________________________

**Telephone:**____________________________________**Fax:**_____________________________

**Claim Number:**__________________________________________________________________

**If this referral is regarding a Veteran, Armed Forces or RCMP member, please include:**

**File Number:**___________________________**Benefit Number:**_____________________________

**Client Number:**_________________________**Authorization:**_______________________________

**Has this client had a psychological assessment or treatment in the past? (If so, please indicate date):**_________________________________________________________________

**Please provide any additional information which you feel would be helpful in the referral process:**______________________________________________________________________

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**May we contact your client directly to book an appointment? Yes_____No_____**