Please fax or email us the completed form:
Fax: (360) 483-0099
Email: Info@parallelwellness.ca

COUNSELLING REFERRAL FORM

Date of Referral: _____ /_____ /_____ (MM/DD/YYYY)

Is the client aware of and agreeable to the referral? Yes ☐ No ☐

Is the referral urgent? Yes ☐ No ☐

Name of Parent/Guardian (if under 18 years)**:**

_____
(First) (Last) (Middle Initial)

CLIENT INFORMATION:

Name: _____
(First) (Last) (Middle Initial)

Birthdate: _____ /_____ /_____ (MM/DD/YYYY) **Age:**_____ **Gender:** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone (home): _____ **May we leave a message?** Yes ☐ No ☐

Phone (mobile): _____ **May we leave a message?** Yes ☐ No ☐

REFERRING PROFESSIONAL:

Name:_____
(First) (Last) (Middle Initial)

Practice: _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Thank you for your referral!

900 - 2025 Willingdon Ave., SOLO District| Burnaby BC | V5C 5T1
Info@parallelwellness.ca
778-990-5491