Mental Optimist

Address: 703- 5255 Yonge St. North York, ON. M2N 5P8
Tell: (437)421-4404 Fax: (647) 480-0980
Email: info@mentaloptimist.com
www.menatloptimist.com

Referral Form for Psychological Treatment and Psychotherapy for Refugees

For insurance purposes, please ensure that all sections marked with an asterisk (*) are completed. Without this Information, IFHP will not accept the treatment plan, leading to interruptions in providing services to the client. Please fax the referral to 1-647-480-0980 or email to info@Mentaloptimist.com

Client's Information*

Client Full Name____________________________ DOB: ______________________

Address ________________________ City ______________ Postal Code ______________

Phone: Cell ____________________ Home: ____________________

Parent/Guardian (if applicable): ________________________

○ **The patient or lawfully authorized substitute decision maker has consented to this referral*.**

Please indicate your **Diagnosis** and **the reason for the referral**. *

Does the Client Require a Translator? Yes No

If yes, please indicate what language ____________________________

Referring Information*

Please complete this section*

Full name of the referring doctor: ____________________________

Name of the clinic or organization: ____________________________

Address: ____

Signature: _______________________________ Date: ______________________________

For insurance purposes, the referring doctor's name, signature, and date are necessary.