# Scarborough Psychology Clinic

**Clinical Director: Dr. Arpita Biswas,** Registered Psychologist
**Practice in Clinical And Counselling Psychology**
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## Referral Form

| | |
|---|---|
| **Date of Referral:** | |
| **Name of the Client** First Name: | Last Name: |
| **Sex (please circle) :** ○ **Male** / ○ **Female** | **Date of Birth** **Month:** **Date:** **Year:** |
| Home Phone: | Cell Phone: |
| Address: | E-Mail: |

**Referral Source: (Place a ✓ in the ☐ of choice)**

☐ Medical Doctor ☐ Other Clinicians ☐ Lawyer ☐ Physio/Rehab clinic ☐ Disability Managers ☐ Others

Name of the Referring Source:

Address:

Tel: Fax:

**Required Services: (Place a ✓ in the ☐ of choice)**

**For:** ☐ Individual ☐ Couple ☐ Family ☐ Group

| **Psychological Assessment** | **Psychological Counselling / Treaments** |
|---|---|
| ☐ Comprehensive Psychological Assessment | ☐ Cognitive Behavioural Therapy |
| ☐ Motor Vehicle Accident Assessment | ☐ Psychodynamic therapy |
| ☐ Disability Assessment | ☐ Mindfulness Based Interventions |
| ☐ Workplace Injuries | ☐ Clinical Hypnosis |
| ☐ Assessment for Immigration purposes | ☐ EMDR |
| ☐ Psycho-vocational Assessment | ☐ Treatments for Anxiety/Depression/Stress |
| ☐ Personality Assessment | ☐ Relationship issues |
| ☐ Intelligence Assessment | ☐ Eating Disorder |
| ☐ Other: _____ | ☐ Other: _____ |