DURAN REFUGEES MENTAL HEALTH SERVICES

Fabiola Duran Pinilla, R.P.

Tel: (647) 979 – 6390 Fax: (647) 492 – 1396

Psychotherapy Patient Referral Form

Date:____________

Patient's Name:______________________________ Contact Information: ________________________

Patients DOB: ______________________________ Patient's IFH#:______________________________

DSM-5 Diagnosis:

_______ Adjustment Disorder _______ Anxiety _______ Depression

_______ Panic Disorder _______ PTSD Other:________________________

Referring Medical Doctor: Signature:

______________________________________ ____

Clinic's Contact Information:

Additional Comments: ____

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Registered service provider:

Immigration, Refugees and Citizenship Canada