



Psychotherapy Referral Form

Please download/save a copy to your computer prior to submitting.

Need help with this form? Call (416) 878-0256 or email karen@karenfreud.com

Patient/Client Information

First Name		Last Name	
Preferred Name		Gender	
		Date of Birth	
Home Phone		Mobile Phone	
Email			
Address			

Consent Confirmation

Has the patient/client given consent for this referral? ☐ Yes (Required)

Optional: Preferred contact method for the patient/client:

☐ Email ☐ Home Phone ☐ Mobile Phone ☐ Unknown / no preference

Reason for Referral

Primary Concerns (check all that apply)

- | | | |
|--|--|---|
| ☐ Anxiety / excessive worry | ☐ Stress, burnout, or overwhelm | ☐ Self-esteem / confidence |
| ☐ Grief or loss | ☐ Identity or life transition | ☐ Addiction recovery aftercare |
| ☐ Depression / mood | ☐ Chronic pain / illness / health | ☐ Coping |
| ☐ Other (Specify) | | |

Additional Comments / Context

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Referring Professional Information

Name		Title/Role	
Type of Practice/Organization			
Email		Phone	
Address			

CLICK HERE TO SUBMIT

or email securely to: referral@karenfreud.com