BALANCE
PSYCHOLOGY & BRAIN HEALTH

REFERRAL FORM FOR HEALTH CARE PROFESSIONALS

Date: _____ / _____ / _____
day month year

Referrer: _____ _____
(print name) (signature / stamp)

Address: _____

Telephone: _____ **Fax:** _____

CLIENT INFORMATION

Client Name: _____ _____
(Last) (First)

Address: _____

Telephone: _____ **Alternate Contact:** _____

Date of Birth: _____ / _____ / _____ **Date of Injury (if applicable)** _____ / _____ / _____
day month year day month year

Diagnoses: _____

Brief Description of Presenting Problem:

_____

_____

Service(s) Requested:

- ☐ Neuropsychological Assessment
- ☐ Psychological Assessment / Treatment
- ☐ Cognitive Behavioural Therapy for Insomnia
- ☐ Memory & Aging Program (worried-well)
- ☐ Mild Cognitive Impairment program
- ☐ Cognitive Rehabilitation
- ☐ Other _____

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Calgary, AB, T2P 3T8

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CURRENT SYMPTOMS/COMPLAINTS

☐ Pain	☐ Dizziness	☐ Balance
☐ Headache	☐ Nausea	☐ Motor abilities
☐ Photo / Phono phobia	☐ Vomiting	☐ Ambulation problems
☐ Blurred vision / Diplopia	☐ Sleep disturbance	☐ Personality changes

Other/Comments: _____

_____

Psychological Status: Please describe any areas of concern (e.g., anxiety, depression, trauma, etc.)

_____

_____

Cognitive Status: Please describe any areas of concern (e.g., attention, memory, language, etc.)

_____

_____

Enclosed Information:

☐ CT Scan	☐ Physiotherapy Report	☐ Neurology Report
☐ MRI Scan	☐ Occupational Therapy Report	☐ Psychiatry Report
☐ X-Ray	☐ Speech Language Pathology Report	☐ Geriatrician Report
☐ Physician Consultation/Progress Report		☐ Psychology Report
☐ Cognitive Screening Tests (e.g., MMSE; MoCA)		☐ Social Work Report

Other: _____

_____

Other Queries or Comments: _____

_____

_____

Thank you for your referral.

Please send this form to the confidential fax number: (403) 764 - 0772.

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