University of Victoria
Psychology Clinic | Department of Psychology
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Client Assessment Referral Form

Referral Date: (dd/mmm/yyyy):_____

Name of Client: _____ Date of Birth (dd/mmm/yyyy):_____

Address/City: _____ Postal Code_____

Phone #: _____ Alternate Phone #: _____ Email:_____

If client is a child (under 19 years of age) or under guardianship, please provide:
Name of parent or guardian: _____ Phone #:_____
Email: _____

If referring for a child/adolescent, is the child aware of and agreeable/prepared to complete this assessment, which includes 2 full days of testing? (yes/no) _____

Referral Source: _____

Phone: _____

FAX: _____

Address/City: _____

Postal Code: _____

Client informed of referral? (yes/no) _____ Client informed of fee? (yes/no) _____

Client's Physician (if different from Referral Source above):_____
Phone: _____ FAX: _____

Referral Question: (clearly state goal of assessment and areas of functioning that require assessment)

_____
_____
_____

Previous assessments: (please attache previous assessment/medical reports, school records, etc.)

_____
_____

Patient medical and birth development history: (including current medications) *If referral is for a child, has hearing and vision been thoroughly assessed? Our assessment may require this to be done before testing occurs.

_____
_____
_____

Family Medical History:

_____
_____