West Coast Psychological Services

Today's Date:

Youth (Other) Referral Form

Referral Source Contact Information		
Your relationship to the person being referred	(i.e. – mother, father, guardian…)	
Your Name (first and last)		
Email		
Phone or Cell #:		**Fax:**

Type of Assessment (choose more than one if applicable)

- ☐ Psychovocational / Career Planning
- ☐ Psychoeducational / Learning Disability
- ☐ Neuropsychological
- ☐ Psychoeducational / Learning Disability with ADHD
- ☐ Psychological / Mental Health
- ☐ Other

Purpose of Assessment

- ☐ Independent Medical Examination (IME)
- ☐ Medical-Legal
- ☐ PWD application
- ☐ None of the above

Client Information		
First Name:	**Last Name:**	**Age:**
Address (City only)		
Brief description of concerns:		

Please return completed form to our office by mail (#620-1285 W. Broadway, Van, BC V6H 3X8) or fax (604-709-0667). Our receptionist will connect with you within one business day of receiving your request. If necessary, Dr. Klancnik (or a designated Registered Psychologist from WCPS) will conduct a free phone consult with you to determine if an assessment would meet your needs.

We look forward to speaking with you.
Thank you for choosing West Coast Psychological Services.

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