West Coast

Psychological Services

Today's Date:

Agency Referral Form

Referral Source Contact Information		
Name of Referral Source		
Address of Referral Source		
Name of Case Manager		
Email		
Phone:	**Fax:**	

- ❑ **I (as the Case Manager) would like to be the liaison** between WCPS and my client with respect to informing the client of the time and place of the appointments

or

- ❑ **I would like WCPS to connect directly with my client** with respect to the details of the time and place of the appointments and inform me once they have been confirmed.

Type of Assessment (choose more than one if applicable)

- ☐ Psychological / Mental Health
- ☐ Neuropsychological
- ☐ ASD Autism Spectrum Disorder
- ☐ Other
- ☐ Psycho Educational / Learning Disability
- ☐ Psycho Vocational / Career Planning
- ☐ ADHD

Purpose of Assessment

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

Client Information				
First Name		**Last Name**		**Title:**
Address City only				**Age:**
Phone or Cell #:		**Email:**		
Brief description of request and referral questions (please add an additional pages if more space is required):				

Please return completed form to our office by mail to West Coast Psychological Services, #240 – 601 Sixth Street, New Westminster, BC V3L 3C1, or email to *admin@wcpservices.com*.
Our receptionist will respond within one business day of receiving your request.
Thank you for choosing West Coast Psychological Services.

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