

West Coast

Psychological Services

Self-Referral Form

Today's Date: _____

Client Information			
First Name		Last Name	Title:
Address (City only)			Age:
Email			
Phone or Cell #:	Fax:		
Brief description of your concerns:			

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

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@wcpsservices.com. Our receptionist will respond within one business day of receiving your request.

If necessary, WCPS will conduct a free phone consult with you to determine if an assessment would meet your needs. Thank you for choosing West Coast Psychological Services.

Version 6.0