

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)

- | | |
|--|---|
| <input type="checkbox"/> Psychological / Mental Health | <input type="checkbox"/> Psycho Educational / Learning Disability |
| <input type="checkbox"/> Neuropsychological | <input type="checkbox"/> Psycho Vocational / Career Planning |
| <input type="checkbox"/> ASD Autism Spectrum Disorder | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Other | |

Purpose of Assessment

- | | |
|--|--|
| <input type="checkbox"/> Independent Medical Examination (IME) | <input type="checkbox"/> Medical-Legal |
| <input type="checkbox"/> Personal | <input type="checkbox"/> 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 to West Coast Psychological Services, #240 – 601 Sixth Street, New Westminster, BC V3L 3C1 or email to admin@wcpervices.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.

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