BelMind Therapeia

CLIENT REFERRAL FORM

101 N Syndicate Ave #405, Thunder Bay, ON P7C 3V4
Phone (437) 324-0430 · (807) 357-2301 Fax 844-799-0146
info@belmindtherapeia.com www.belmindtherapeia.com

1. Client information

Full name

Date of birth (YYYY-MM-DD)

Address

Phone

Email

Emergency contact (name and phone)

Best way / time to reach the client

2. Consent to contact

The client consents to be contacted by BelMind Therapeia by:

☐ Phone ☐ Email

Please confirm the client has agreed to be contacted before submitting this referral.

3. Service requested

☐ Individual therapy ☐ EMDR ☐ Couples / relationship counselling ☐ Other:

4. Presenting concerns (check all that apply)

☐ Depression / sadness
☐ Anxiety / panic
☐ Trauma / PTSD symptoms
☐ Grief / loss
☐ Substance use
☐ Sleep problems
☐ Anger / irritability
☐ Social withdrawal
☐ Family / relationship stress
☐ Suicidal thoughts
☐ Hallucinations / paranoia
☐ Other:

5. Brief notes on primary concerns

6. Referrer information

Referred by (name)

Contact (phone or email)

Clinic / organization (if applicable)

Date of referral

This form contains personal health information. Please send it by fax to 844-799-0146 or by email to info@belmindtherapeia.com.

Thank you for the referral. Your trust honours the healing journey.