Oak Tree Therapy
209-2110 Main Street
Phone: (204) 336-2144
Winnipeg, Manitoba R2V 2C2
oaktreetherapy@outlook.com

REFERRAL FORM

Date of Referral: _____

Date Service is requested: _____

Location Service is requested: _____

Agency (if applicable): _____

Social Worker Name: _____ Email: _____ Ph: _____

Supervisor Name: _____ Email: _____ Ph: _____

Client's Name: _____

Date of Birth (required): _____ **Treaty number** (required) _____

Legal Status (if in foster care): _____

Parent/Care provider/foster parent name(s): _____

Address (required): _____

Phone Number (required): _____ Email (required):_____

Formal Diagnosis (Suspected), if any: _____

Is there a psychological, FASD, CDC, or other assessment on file? Yes/No (Please Provide Copy with Referral)

Is there a specific modality of therapy being requested? (Play therapy, MIG, EMDR, etc.) _____

Why is the individual, family or child being referred? (Please list worries, concerns, behaviours, life changes, etc to be addressed by therapeutic services). _____

*** A social History is not required but is greatly appreciated at time of referral or shortly thereafter. ***