Centre ADAPT Centre
50 rue du Marché, Suite 230
Dieppe, NB
E1A 9K2

REFERRAL FORM: REQUEST FOR PSYCHOLOGICAL SERVICES

SUBJECT'S DEMOGRAPHIC INFORMATION:

Family Name: _____ First name; _____

D.O.B.: _____/_____/_____ Phone : _____ (Cell)
_____ (Home)
_____ (Work)

Email address: _____

If services are requested for a **Veteran**: K# _____

Other First Responders ID#: _____

If services are requested for an adjudication or a return to work: Claim # _____

REFERRING AGENT:

Agency (or individual): _____ **Referring agent:** _____

Office Phone #: _____ **Cell #:** _____ **Fax #:** _____

Email address: _____

TYPES OF SERVICE REQUESTED: (Check one or more)

Psychotherapy ☐ **Assessment** ☐ **Clinical Consultation** ☐ **Other** ☐

Psychotherapy *(Indicate one or more)	Clinical consultations and others:
• Anxiety ☐	• In person/Public presentation* ☐
• Depression ☐	• Online presentation* ☐
• Trauma ☐	• Service review ☐
• Adjustment issues ☐	• Debriefing ☐
• Parenting/family issues ☐	• Self-defense workshops for women** ☐
• Parenting fitness ☐	• Occupational/Residual employability ☐
• Gender/trans issues ☐	• Return to Work Prep ☐
• Parenting/family issues ☐	
• Other _____	

*Please specify subject you wish to be presented.

Forensic assessments:	Clinical assessments:
• Risk of physical violence ☐ • Risk of sexual violence ☐ • NBRB ☐ • Psychological health and fitness ☐ • Other ☐ _____ _____	• Full Cognitive Assessment (Intelligence, memory, attention, executive functions) ☐ • Full Psychodiagnostic Assessment (personality, psychopathologies, functional abilities) ☐ • Cognitive Abilities ☐ • Memory Abilities ☐ • Executive Functions ☐ • Occupational/Residual employability ☐ • Return to Work ☐
Date at which the assessment is requested: _____	

COMPLETE THE FOLLOWING QUESTIONS ONLY IF YOU ARE LOOKING FOR A PSYCHOLOGICAL ASSESSMENT FOR SOMEONE ELSE.

Question(s): Please specify the information you are seeking. E.g. risk of sexual violence toward children.

_____

_____

_____

_____

_____

_____

_____

_____

Please indicate which applies:

Known Mental Health Diagnosis? yes ☐ no ☐ Unknown ☐ **Known Criminal Record?** yes ☐ no ☐ Unknown ☐

If yes, specify: _____

_____

_____

Suicidal concerns: yes ☐ no ☐ Unknown ☐ **Homicidal concerns**: yes ☐ no ☐ Unknown ☐

If known, prescribed medications (in particular, psychotropics, anxiolytics and antidepressants).:

Other information relevant to this referral: _____

PLEASE ATTACH OR FORWARD ANY PERTINENT DOCUMENTATION (psychological and psychiatric reports, other relevant medical information, police report, victim statements and/or victim impact statements, etc.).