Urquhart Program Referral Form

Referring Provider Information

Name: _____

Organization: _____

Contact: _____

Client Information

Name: _____

Phone: _____

Email: _____

Address: _____

_____

Date of Birth: _____

Medicare: _____

Primary Reason for Referral

- ☐ Birth/postpartum trauma
- ☐ Postpartum anxiety
- ☐ Postpartum OCD
- ☐ Postpartum depression
- ☐ Loss/grief
- ☐ Pregnancy
- ☐ Other- Please explain:

Permissions

I have obtained permission from the above-named client for this form to be shared electronically with Gentle Path Counselling Services. This includes communication via email and fax.

Signature: _____ Date: _____

Acknowledgement of Financial Responsibility

I have ensured my client understands that as the referring provider, I am not financially responsible for any services provided by the Urquhart program.

Signature: _____ Date: _____

Please send to **Gentle Path Counselling Services** by email: referrals@gentlepathsj.com or by fax at (506) 672-1783. Questions? Reach us by phone at (506) 652-7284.