

Urquhart Program Self-Referral Form

Client Information

Name: _____

Phone: _____

Address: _____

Email: _____

Preference for sessions:

In person

Virtual

Primary Reason for Referral

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

Permissions

I, _____, give permission for this form to be shared electronically with Gentle Path Counselling Services. This includes communication via email and fax.

I would like to opt in to phone check-ins at 1 week, 1 month, 3 months, and 6 months postpartum.

I understand that I can change this decision during any of these check-ins. By opting in, I consent to my name and phone number being securely stored for the purpose of these follow-ups.

Delivery date: _____ Expected discharge date: _____

Acknowledgement of Financial Responsibility

I understand that I will be 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.