Strathroy Trauma Therapy
& COUNSELLING CENTRE

17 Frank Street, Unit 3, Strathroy, ON N7G 2R2
Phone: 226-456-8822
Fax: 226-457-4187
Email: info@strathroytherapy.ca
www.strathroytherapy.ca

Referral Form

1. Client Information

Client Name: _____

Date of Birth: _____ Phone: _____

Email: _____

Address: _____

_____

2. Reason for Referral

- ☐ Trauma / PTSD
- ☐ Anxiety
- ☐ Depression
- ☐ Grief / Loss
- ☐ Couples / Family
- ☐ EMDR
- ☐ Workplace Injury / WSIB
- ☐ Motor Vehicle Accident
- ☐ Other: _____

Brief reason / relevant concerns:

_____

_____

_____

_____

3. Referring Physician / Provider

Referring Physician / Provider Name: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

☐ Client is aware of and consents to this referral.

Please fax completed referral to: 226-457-4187

Referral forms are available at strathroytherapy.ca