



C2 CENTRE

for brain health

Psychology · Neuropsychology

REFERRAL FORM

Fax: 844.260.4710 | info@c2centre.com | SecureDocs

CLIENT INFORMATION

Name (Last Name/ First Name): _____

DOB (dd/mm/yyyy): _____

Gender: _____

Address: _____

Email: _____

Phone: _____

Person making referral: _____

Phone / Fax: _____

INTAKE INFORMATION

History (brief): _____

Purpose of Referral: _____

Service (circle one):

Psychological Therapy | Psychological Assessment | Neuropsychological Assessment

Primary Concern: _____

Active co-morbidities: _____

*Attach additional relevant information (e.g., Past medical history, medication list, test results (e.g., MMSE, neuroimaging results), relevant consultation reports, etc.).