

Dr. Sare Akdag, RPsych

Expertise in Pediatric Neuropsychology and Assessment

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REFERRAL FOR PSYCHOLOGICAL SERVICES

Child's Name: _____

DOB (mm/dd/yyyy): _____ **Sex:** M F

Parent/Legal Guardian's s Name(s): _____

Address: _____

Home Telephone Number: _____

Other Telephone Number: _____

Person Making Referral: _____

Relationship to Child: _____

Referral Person's Address: _____

Referring Person's Telephone Number: _____

Referring Person's Fax Number: _____

Email: _____

Has this referral been discussed with the child's parent/legal guardian? Y N

Was consent from the parent/legal guardian obtained to release information to Dr. Akdag? Y N

Type of Service Being Requested:

Neuropsychological Assessment

Psycho-educational Assessment

Consultation

Reason for Referral (please include relevant reports or letters in support of this referral such as previous assessments, medical notes, school reports, etc):

Please FAX completed referral forms to Dr. Akdag at 604-648-8464