

**Referring to: Yue (Emily) Jiang, Registered Psychotherapist (Qualifying)
Please Fax OR Email**

ShineRoot Psychotherapy & Wellness

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Address: 7800 Woodbine Avenue, Unit 205, Markham, Ontario, L3R 2N7



REFERRAL FORM (respond within 1–3 business days)

PATIENT INFORMATION

*Legal Name (First, Middle, Last): _____

*DOB (mm-dd-yyyy): _____ * Phone: _____

*Email: _____

REFERRING PROVIDER INFORMATION

*Name (First, Middle, Last): _____

*Clinic: _____ *Email: _____

*Phone: _____ *Fax: _____

***REASON FOR REFERRAL (check all that apply)**

- | | |
|--|--|
| <input type="checkbox"/> Anxiety / panic | <input type="checkbox"/> Grief / loss |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Parenting / family issues |
| <input type="checkbox"/> Depression / low mood | <input type="checkbox"/> Emotional regulation difficulties |
| <input type="checkbox"/> Trauma / PTSD | <input type="checkbox"/> MVA |
| <input type="checkbox"/> Stress / burnout | <input type="checkbox"/> EAP |
| <input type="checkbox"/> Relationship / couples concerns | <input type="checkbox"/> Other: _____ |

***RISK / URGENCY**

- No immediate safety concerns identified
- Mild/moderate risk concerns
- Urgent follow-up recommended

If urgent/imminent risk present, please refer to emergency services/departments.

MEDICATION / CLINICAL NOTES: (optional)

***CONSENT**

- Patient is aware of referral and patient consents to be contacted by therapist

Physician Signature: _____

Date (mm-dd-yyyy) _____