

**Shikha Harish, MA, Psych  
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**Referral Form to be faxed at 905-230-4014**

CAS Worker \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax \_\_\_\_\_

Name of the Client \_\_\_\_\_

Client's Contact Number \_\_\_\_\_

Reason for the Referral

Date the report/ letter is needed: \_\_\_\_\_ Please fax • The relevant file material regarding the client including a synopsis of the index offence (s), disclosure etc. • Any clinical or psychological reports in the file • Signed Consent form for two way communication

Signatures \_\_\_\_\_ Date \_\_\_\_\_

Note: The services are not covered under OHIP. However, these services are eligible for coverage under extended health care plans. If you have a health care plan, it is recommended you check with your plan provider to determine the extent of your coverage for the services of a registered psychotherapist. Please refer to my Fee Policy on the website