PINEAPPLE THERAPY REFERRAL FORM

Please complete the following referral form with your client. Once completed, Please fax the referral form to Pineapple Therapy at +1-431-340-7406.

PINEAPPLE THERAPY

#100 10004 79 Avenue, NW
Edmonton, AB T6E 1R5
PH # 587-735-2303
FAX # 1-431-340-7406
www.pineappletherapy.ca

Client Information	
First Name:	Last Name:
Date of Birth:	Address:
Phone Number:	Email Address:
Preferred Contact Method: ☐ Phone ☐ Email	

Referral Source	
Name of Referrer:	Referrer Title: ☐ Dietitian ☐ Nurse ☐ Counsellor/Therapist ☐ Health Care Provider ☐ Doctor/Endocrinologist ☐ Other
Phone Number:	Email Address:
Date of Referral:	

Referral Information

Primary Reason for Seeking Therapy/Reason for Referral:

Symptoms/Concerns: (select all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Burnout
- ☐ Diabetes Distress
- ☐ Diabetes Management
- ☐ Other (please describe below)

Preferred Counsellor/Therapist:

- ☐ Has lived experience with Diabetes
- ☐ Male identifying
- ☐ Female Identifying
- ☐ Other (please describe below)

Insurance Information

Does the client have insurance coverage for counselling services?

- ☐ Yes
- ☐ No

If yes, please provide the Insurance Provider Name:

If no, is the client open to working with an intern therapist at a reduced rate/sliding scale?

- ☐ Yes
- ☐ No

I hereby consent to the sharing of my personal and health information between Pineapple Therapy and my referring provider as necessary for the purpose of treatment and healthcare operations. I understand that this consent is voluntary and can be revoked by me at any time in writing, except to the extent that actions have already been taken based on this consent.

_____ _____

Client Signature Date

_____ _____

Referrer Signature Date