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REFERRAL FORM

PLEASE FAX AT 905-230-4014

Child Protection Worker: _____

Address _____

Phone: _____

Fax: _____

Name of the Client: _____

Phone _____

Reason for Referral

Is the case Active with CAS? _____

Please fax

- The relevant material regarding the involvement of the family with CAS to manage the case in an efficient way.
- Any legal, clinical or psychological reports
- Signed Consent form for two way communication

Comments: _____

Date: _____

Signatures: _____

Note: The services are not covered under OHIP. However, psychological 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 the psychologist.