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| CONFIDENTIAL FAX  |
| **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Send to**: Dr. Paula Miceli, C. Psych,Psychologist | **From**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Office Location**: TS Medical Centre, 692 Euclid Avenue, Toronto, ON  | **Office Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Phone Number:** (416) 275-3735 | **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Fax Number:** (416) 901-7217 | **Number of Pages, Including Cover**: 1 |
| Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_indicate the dates of service and other service-related information (duration, cost) that requires confirmation in the table below. A doctor’s signature in the verification column is an attestation of all service details noted in the same row. any items that cannot be verified will be specified. |

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| --- | --- | --- | --- |
| SERVICE DATE | LENGTH | COST | VERIFICATION |
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Comments:

Dr. Paula Miceli, C. Psych,

Registered Psychologist