CSCH-OD Referral Information sheet

(Submit only if you want to accept or modify referrals – full members and fellows only)

Your name: ____

Which of the following conditions do you ***have training & experience in treating*** and for which you would receive referrals?

□ Allergies
□ Age Regression
□ Anxiety
□ Bereavement
□ Conversion Disorder
□ Chronic / Terminal Illness
□ Depression
□ Eating Disorders
□ Forensic Issues
□ Habits (e.g., thumb-sucking)
□ Health Promoting Behaviours
□ Hypnoanalysis
□ Obsessive Compulsive Disorders
□ Pain - Acute
□ Panic Disorder
□ Phobias
□ Rehabilitation
□ Self Esteem
□ Sexual Trauma
□ Skin Problems & Rashes
□ Smoking Cessation
□ Weight Loss
□ Addictions
□ Anger Management
□ Bedwetting Children
□ Childhood Trauma
□ Couple Therapy
□ Dental Phobias
□ Dissociative Disorders
□ Ego Strengthening
□ Group Therapy
□ Headaches
□ Hot Flashes
□ Irritable Bowel Syndrome
□ Obstetrical Delivery
□ Pain - Chronic
□ Performance Enhancement-Sport
□ Posttraumatic Stress Disorder
□ Self Injurious Behaviours
□ Sexual Dysfunction
□ Sexual Orientation
□ Sleeping Disorders
□ Stress Management & Relaxation

Do you work with:
□ Children younger than 5
□ Children older than 5
□ Adolescents
□ Adults
□ Geriatrics

What other conditions would you like to see as categories in this list?
Please make changes, scan and send to MemberChanges@csch-od.ca or print and send to:
CSCH-OD Membership, 2321 Ave. Regent, Montreal, QC, H4A 2R2

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