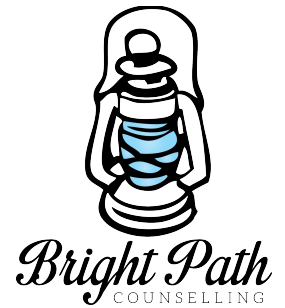


# COUNSELLING REFERRAL FORM



Date of Referral: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (DD-MM-YYYY)

Is client aware of and agreeable to this referral?  Yes  No

Is this referral urgent?  Yes  No

## CLIENT INFORMATION

Name: \_\_\_\_\_  
*Last First Middle Initial*

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/guardian (if under 18 years): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Cell Phone: \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_

May we email?  Yes  No

*\*Note: Email is not considered to be a confidential medium of communication.*

## REFERRING PROFESSIONAL

Name: \_\_\_\_\_  
*Last First Middle Initial*

Practice: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_



**REASONS FOR REFERRAL (PRESENTING PROBLEMS):**

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**ANY RELEVANT MEDICAL OR PSYCHIATRIC HISTORY?**

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**ANY HISTORY OF AGGRESSIVE BEHAVIOUR AND/OR SELF HARM?**

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**OFFICE USE: RECEIVED BY ...**

\_\_\_\_\_  
*Counsellor Signature*

\_\_\_\_\_  
*Date*