# Counselling Referral Form

Bright Path COUNSELLING

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)

**Any Relevant Medical or Psychiatric History?**

**Any History of Aggressive Behaviour and/or Self Harm?**

OFFICE USE: RECEIVED BY ...

*Counsellor Signature* *Date*