COUNTSELLING 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*