Referral - COUNSELLING SERVICES

Client Name: ______________________________ NEW or RETURNING

Phone: ____________________ Cell: ____________________ Message: YES NO

Date of Birth: ______________ (dd/mm/yyyy) Care Card Number: ____________________

Parent(s)/Guardian(s) Name (if PEACE): ______________________________

Referral Source: ______________________________

Referral Contact Details: ______________________________

Mental Health
Addictions/Dependency
BOTH

Women's Services / Stopping the Violence (STV)
PEACE (Children & Youth Experiencing Violence)
Other: ____________________

YES	NO	
		Are there any immediate concerns for client's physical safety?
		Having suicidal thoughts (have made plans, attempts?)
		Are there children in the home?
		Are there child protection concerns?
		Is the client currently taking prescribed medication?

Details:

What is the client's goal in treatment?:

Completed by: ______________________ Date: ______________ (dd/mm/yyyy)

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