ADULT REFERRAL COUNSELLING FORM

This form is to be completed by the Referrer

THIS FORM IS CONFIDENTIAL

First and Last Name:

Address:

Home Telephone:

Email:

Date of Birth: ________ / _______ / ________ Age:

Gender: Male ☐ Transgender ☐

Female ☐ Additional Category ☐

Name of the organization referring:

Name of the person referring behalf of the organization:

Address of Organization:

Date of Referral ________/ ________ /________

If self-referring (name):

Address:

Please describe in detail the presenting concerns.

	YES	NO
Are there any past or current mental health difficulties?	☐	☐

If YES, please provide details (i.e. diagnosis, how long):

Are you/client presently taking any medication prescribed by a doctor?	☐	☐

Please list medications:

Are there any other health problems that we should know of? If yes, please provide details?

Any other services, supports, or agencies that are involved? If YES, please describe:

Please describe relevant background information that will help assist in therapeutic and counselling services.

Who are primary supports/attachments (i.e.: partner, friend, sibling)?

Are there any other areas of concern that we should know about that you feel may require support?

If you would like to see a specific therapist, please write their name here:

How did you hear about us?

PLEASE INCLUDE ANY RELEVANT PRIOR ASSESSMENTS OR INFORMATION PERTINENT TO OUR UPCOMING WORK

TO BE COMPLETED BY THE COUNSELLOR UPON COMPLETION

OUTCOME OF ASSESSMENT: