

CONFIDENTIAL

Community Counselling Service Referral Form

Name: ……………………………………………………………….

Title……………… Pronoun ………………………………………

Date of birth: ……………………………………………………………

Address: …………………………………………………………………

……………………………………………………………………………...

……………………………………………………………………………..

Phone number………………………………………………………….

Email address …………………………………………………………

Date of referral: …………………………………………………………

Referral made by: ………………………………………………………

Reason for Referral – Please tell us why you would like counselling:

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

Signature of client or parent/guardian if client is under 16 years of age:

……………………………………………………………………………………….

Please let us know if you require any additional support during appointments:

(e.g., interpreter, disabled access etc)

…………………………………………………………………………………………

…………………………………………………………………………………………

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OFFICE USE ONLY:

Date received:

Received by:

Acknowledged on:

Assessment appointment:

Notes