Referral - COUNSELLING SERVICES

Client Name: ____ ❒ NEW or ❒ RETURNING

Phone: (hm)____________________(other) ______________________ Message OK? ❒ YES or ❒ NO

Date of Birth: ______/________/______ (dd/mm/yyyy) Care Card Number: ______________________

Parent(s)/Guardian(s) Name (if CWWA): ____

Referral Source: ____

Referral Contact Details: ____

❒ Mental Health	❒ Women's Services / Stopping the Violence (STV)
❒ Addictions/Dependency	❒ Children Who Have Witnessed Abuse (CWWA)
❒ BOTH	❒ 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: ____

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What is client's goal in treatment?: ____

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Completed by: ________________________________ Date: ______/________/______ (dd/mm/yyyy)

IN CLEARWATER
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