Erinnah
Counselling & Therapy

REFERRAL FORM

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: ________________ State: ______ Postal Code ____________

Home Phone: ________________ May we leave a message? ☐ Yes ☐ No

Mobile Phone: ________________ May we leave a message? ☐ Yes ☐ No

E-mail: ____

May we email? ☐ Yes ☐ No

REFERRING PROFESSIONAL

Name: ____

Agency: ____

Address: ____

City: ________________ Post code ____________

Phone: ________________

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 ...

Date