REFERRAL FOR ADULT COUNSELLING

Date of Referral:

CLIENT DETAILS

Name:

Address:

Phone: **DOB**: **Age:**

Ethnicity: **Iwi**:

Gender: **Pronoun:**

Preferred Name:

Has this client attended counselling at MCH previously?

Contact via:

Children in Client's Care? **Age/s:**

Protection Order in Place?

Any accessibility needs?

EMERGENCY CONTACT DETAILS

Name:

Address: **Phone**:

Relationship to Client:

REFERRER INFORMATION

Name:

Organisation:

Email: **Phone**:

Services currently delivered:

ARE ANY OTHER AGENCIES SUPPORTING THE CLIENT?

Organisation:

Key Worker: **Phone**:

Email:

Services currently delivered:

IS THE CLIENT AWARE OF THIS REFERRAL?

REASON FOR REFERRAL

Background:

Current Issues:

For office use only:	Received:	Triaged:
	Allocated:	Waitlisted:
	Counsellor:	Funding: