Counseling Referral Form

CLIENT INFORMATION

Name: _____ Age: _____

Date of birth: _____ dd / mm / yyyy Sex: _____

Address: _____ Contact information: _____

Relevant medical/health history:

Date of referral: _____ dd / mm / yyyy

DETAILS OF THE PERSON REFERRING

Name: _____ Title/position: _____

Role performed while referring: _____ Contact information: _____

Address: _____

REFERRED SPECIALIST DETAILS

Name: _____ Title/position: _____

Organization/practice name: _____ Contact information: _____

Clinic/office address: _____

REASON FOR THE REFERRAL

Please select the reason(s) for referring the individual to counseling:

Please provide a description of any significant incident(s) or specific example(s) of the behavior(s):

Actions taken by the person referring (or anyone else):

Any risks to the individual or others that should be highlighted:

Has the individual received any previous counseling or mental health services?

◯ Yes ◯ No

If yes, please provide details:

How urgent is the referral? (0 – not important, 10 – extremely important):

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10