ADULT REFERRAL COUNSELLING FORM

This form is to be completed by the Referrer

THIS FORM IS CONFIDENTIAL

First and Last Name:

Address:

Home Telephone:

Email:

Date of Birth: __________ / _______ / __________

Gender: Male ☐ Transgender ☐

Female ☐ Additional Category ☐

Your name, if different than above:

Date of Referral: __________ / _______ / __________

Briefly describe the presenting concerns:

Are there any past or current mental health difficulties? YES NO

If YES, please provide details (i.e. diagnosis, how long):

Are you/your client presently taking any medication prescribed by a doctor?
If you answered YES, please list medications here:

Are there any other health problems that we should know of? If YES, please provide details:

Are there any other services, supports, or agencies involved? If YES, please describe:

Please describe relevant background information that will help assist in therapeutic and counselling services.

Who are your/the primary supports/attachments (i.e.: partner, friends, sibling)?

Are there any other areas of concern that you feel may require additional support?

If you would like to see a specific therapist, please write their name here:

How did you hear about us?

PLEASE INCLUDE ANY RELEVANT PRIOR ASSESSMENTS OR INFORMATION PERTINENT TO OUR UPCOMING WORK

Which of our two locations works best for you? St. Malo Winnipeg

TO BE COMPLETED BY THE COUNSELLOR/THERAPIST UPON COMPLETION

OUTCOME OF ASSESSMENT: