DIVERSE*city* OFFICE USE ONLY

Referral Received Date: ______________________________ Counsellor Assigned: ________________________________

Assigned Date: ______________________________________ Assigned By: ______________________________________

COUNSELLING SERVICES ADULT REFERRAL FORM

Referral Guidelines

- Incomplete forms will not be accepted.
- A referral does not guarantee service. All referrals are screened prior to an intake interview.
- If you require notice of intake and assignment, please indicate below. Referring persons will be notified via email with the name of the assigned counsellor and anticipated start date.

Please note: any additional information sharing requires the client's consent.

Referral Program

Please pick **ONE** program and the corresponding language:

☐ Family Counselling

☐Arabic ☐Hindi ☐Korean ☐Mandarin ☐Punjabi ☐Spanish ☐Urdu

☐ Multicultural Women's Stopping the Violence (STV) Program

☐Arabic ☐Farsi ☐Hindi ☐Korean ☐Mandarin ☐Punjabi ☐Spanish ☐Urdu

☐ Substance Use Counselling

☐Punjabi ☐Spanish

Referral Information

Name: ____ Agency/Relationship to Client: ______________________________

Email: ____ Phone Number: ____

Date of Referral: ________________________________ Notification of assignment & anticipated start date: ☐Yes ☐No

Has this referral been discussed with the client: Yes ☐ No ☐

Client Information

Primary Client Name: ______________ ______________ Date of Birth: ______________________ Gender: __________

(First name) (Last name) (year/month/date)

Address: ____ City/Province: __________________ Postal Code: ___________

Language: __________________ Ethnicity: _________________ Primary Phone #: ________________ Alt. #: _________________

Please indicate names and ages of other family members: (***Family Counselling only)*** ______________________________________

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Primary Reason for Referral ***(Please be specific and provide relevant details to ensure meeting program criteria)*:**

(Please attach additional notes as necessary)

Goals for Counselling:

1) ____

2) ____

3) ____

Please complete and submit the form online to counsellingservices@dcrs.ca or via fax.