DIVERSEcity
community resources society

DIVERSEcity 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:** ☐ Farsi ☐ Hindi ☐ Mandarin ☐ Punjabi ☐ Urdu

☐ **Substance Use Counselling:** ☐ Punjabi ☐ Spanish

☐ **Women in Conflict with the Law:** ☐ Hindi ☐ Korean ☐ Punjabi ☐ Urdu

☐ **Domestic Violence Survivors Outreach Group:** ☐ Hindi ☐ Punjabi ☐ Spanish ☐ Urdu

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)***

____

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.