tiqvah
Counselling & Wellbeing

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Referral Form

Please answer the following questions to the best of your abilities. This information is held to the same standards of confidentiality as our therapy sessions.

Referring Agency

Referring entity: ______________________________ Date of referral: __________
Program: ____
Name of person referring: __________________________
Contact details: (ph) __________________ (Email)__________________________
Does the prospective client consent to this referral? Yes☐ No☐

Prospective Client Details

Client Name: ____________________________ DOB: __________ Gender: _________
Home Address: ____
Contact details: (ph) __________________ (Email)__________________________
Emergency contact: (Name) ____________________ (Number) __________________

Service Requested (please check the requested service):

1. Individual Counselling	☐	
2. Older Persons Counselling	☐	(Please speak with your Coordinator to include Counselling in your package).
3. Wellbeing (NDIS Clients only)	☐	If client is on an NDIS program please mark from the options below:
		Assistance with Daily Living ☐
		Employment ☐
		Improved Daily Living ☐
		Improved Relationships ☐

Additional information:

____
____
____

Other agencies/professional services involved:

____
____
____

What is the reason for you seeking counselling?

____

Are there any Court Orders? Yes ☐ No ☐

Are there any safety concerns? Yes ☐ No ☐
If yes please describe: ____

If for a minor/Child protection related, has Safety Planning been conducted? Yes ☐ No ☐

How will you pay the fees?
NDIS Plan Mannaged: ☐ Referring agency: ☐ Own funds: ☐

Client Signature:_________________________ Date: _______________