Counseling Referral Form

Client information	
Name:	Age:
Date of birth:	Sex:
Address:	
Contact information:	Date of referral:
Relevant medical/health history:	
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 referral	
Please select the reason(s) for referring the individual to counseling:	
☐ Violence ☐ Impulsive behavior ☐ Always tired ☐ Anxious ☐ Change in behavior ☐ Bullying (victim/bully) ☐ Challenging behavior ☐ Lack of motivation	☐ Self-harm ☐ Drug use ☐ Threat to other’s safety ☐ Alcohol abuse ☐ Scared ☐ Nervous ☐ Other (Specify):

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