# CSC REFERRAL FORM

☐ COUNSELLING ☐ CRISIS RESPONSE ☐ SOCIAL WORK

COUNSELLING services centre

**Referrals to be emailed to:** admin@cscnz.org.nz

**CSC #**

## CLIENT DETAILS

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Clients Name** | | | | | | | **Female** | **Male** |
| | First Name(s) | | | | Surname | | | |
| **Address** | | | | | | **DOB** | | |
| **client under 18?** | YES | NO | **AGE** | | Legal guardian/Parent if under 18 | | | |
| **Ethnicity** | | | **Phone** | | **Mobile** | | | |
| **Preferred appointment days?** | Mon | Tues | Wed | Thurs | Fri | **Safe to leave message?** | yes | no |
| **Preferred time?** | Morning | Afternoon | Evening | | | **Safe to text?** | yes | no |
| **Occupation** | | | | | | **Full-time** | **Part-time** | |

***Reason for referral, relevant info, presenting issues***

## REFERRER INFORMATION

| | | | | |
|---|---|---|---|---|
| **Referrer Name:** | | | **Position Held and organisation:** | |
| **Client/caregiver has been made aware of this referral and consented to CSC contacting the client?** | **YES** | **NO** | | **Please explain if no consent from client?** |
| | | | | **Does client consent to onward referral to other services?** YES / NO |
| OR tick if self-referral received via phone/email | | | | |
| | office | mobile | | email |
| **Referrer signature:** | | | **Date:** | |

## Admin Notes

office use only

**ALLOCATED TO:** **DATE:** **FIRST APT:**

| | |
|---|---|
| **EAP Provider and client #:** | ACC MSD GEN EAP FAM MCOT |

**Date file closed:** **Unable to contact** **No longer required** **Found counsellor elsewhere**