

## Counselling Referral Form

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| <b>Full name of person being referred:</b>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                       |
| Date of Referral:                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                       |
| Who is making this referral?<br><input type="checkbox"/> Self-referral<br><input type="checkbox"/> Family/Friend<br><input type="checkbox"/> Other                                                                                                                                                                                                                                       |                                                                                                                                                                       |
| Referrer's name:<br>Agency/Organisation:<br>Contact phone/email:                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                       |
| Ethnicity:                                                                                                                                                                                                                                                                                                                                                                               | Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender diverse                                                         |
| Address:<br><br>Postcode:                                                                                                                                                                                                                                                                                                                                                                | Date of birth:<br>If the referral is for someone under 18, please provide the caregivers name and contact details:                                                    |
| Home phone:                                                                                                                                                                                                                                                                                                                                                                              | What is the client's preferred method of contact? <input type="checkbox"/> Home phone<br><input type="checkbox"/> Mobile<br><input type="checkbox"/> Email            |
| Mobile:                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                       |
| Email:                                                                                                                                                                                                                                                                                                                                                                                   | Is it ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Is it safe to text? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Preferred appointment days:<br><input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday<br><input type="checkbox"/> Friday                                                                                                                                                                                  | Preferred time:<br><input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening                                               |
| Has the person being referred consented to: <ul style="list-style-type: none"> <li>• This referral? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Our service to contact them directly? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Onward referral to other services? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> |                                                                                                                                                                       |
| Does the person being referred have any dependents in their care? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                               |                                                                                                                                                                       |
| Does the person being referred need an interpreter or any other assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide details)                                                                                                                                                                                                                           |                                                                                                                                                                       |
| Counsellor Gender Preference: <input type="checkbox"/> Female <input type="checkbox"/> Male                                                                                                                                                                                                                                                                                              |                                                                                                                                                                       |
| <b>Reason for referral:</b><br><i>Brief reason for referral/ presenting issues</i>                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                       |
| Email referral form to <a href="mailto:admin@cscnz.org.nz">admin@cscnz.org.nz</a>                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                       |
| <b>For Office use only</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                       |
| Name of person taking referral:                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                       |
| Comments:                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                       |

Please note, the information provided above is confidential to Counselling Services Centre. If you receive this form in error, please treat as confidential and advise us immediately by email [admin@cscnz.org.nz](mailto:admin@cscnz.org.nz) or phone 09 277 9324.

### Privacy Statement

The information provided above will only be used for the purpose of providing counselling or social work services to the person being referred, for reporting and for audit purposes. The information will only be shared with others if the person being referred consents or the disclosure is required by law. The person being referred can update the information at any time by contacting us at the above email address.