COUNSELLING SERVICES CENTRE
Nga Whakahaumarutanga o te Hauora

Counselling Referral Form

Full name of person being referred:	
Date of Referral:	
Who is making this referral? ☐ Self-referral ☐ Family/Friend ☐ Other	Referrer's name: Agency/Organisation: Contact phone/email:
Ethnicity:	Gender: ☐ Female ☐ Male ☐ Gender diverse
Address: Postcode:	Date of birth: 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? ☐ Home phone ☐ Mobile ☐ Email
Mobile:	
Email:	Is it ok to leave a message? ☐ Yes ☐ No Is it safe to text? ☐ Yes ☐ No
Preferred appointment days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	Preferred time: ☐ Morning ☐ Afternoon ☐ Evening
Has the person being referred consented to: • This referral? ☐ Yes ☐ No • Our service to contact them directly? ☐ Yes ☐ No • Onward referral to other services? ☐ Yes ☐ No	
Does the person being referred have any dependents in their care? ☐ Yes ☐ No	
Does the person being referred need an interpreter or any other assistance? ☐ Yes ☐ No (If yes, provide details)	
Counsellor Gender Preference: ☐ Female ☐ Male	
Reason for referral: *Brief reason for referral/ presenting issues*	
Email referral form to admin@cscnz.org.nz	

For Office use only
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 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.