REFERRAL FORM

NAME:	
ADDRESS:	**DATE OF REFERRAL:**
	REFERRAL SOURCE:
PHONE NUMBER: **MARTIAL STATUS:**	**REFERRAL SOURCE PHONE #:**
D.O.B. **AGE:**	**GP:**
OTHER AGENCIES/SUPPORTS INVOLVED: (List contact & duration of involvement if available)	
REASON FOR REFERRAL: **GENERAL COUNSELLING** ☐ **ADDICTION COUNSELLING** ☐ **CONCERNED PERSON** ☐	
ADDITIONAL INFORMATION:	
SUBSTANCE USE (CURRENT SUBSTANCES, AMOUNT, FREQUENCY OF USE, ETC.):	
DOES CLIENT/PATIENT WANT HELP WITH THIS ISSUE? YES NO	
MEDICATIONS:	
RISK ISSUES:	

X

SIGNATURE OF REFERRING AGENCY STAFF: **DATE**: