Mental Health Counselling Request

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| **Please fill out the below information regarding the client you would like to refer.**  |
| **Date:** Click or tap to enter a date. |
| **Client last name:** Click or tap here to enter text. | **Client first name:** Click or tap here to enter text. |
| **Date of Birth:** Click or tap to enter a date. | **Gender:** [ ] Male [ ] Female [ ] Other |
| **Address:** Click or tap here to enter text. | **Postal code:** Click or tap here to enter text. |
| **Phone number:** Click or tap here to enter text. | **Phone number (alt.):** Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. |
| **Preferred method of contact:** [ ] Phone [ ] Alt. Phone [ ] Email [ ] Text |
| **Child lives with (include relationship):** Click or tap here to enter text. |
| **Custody/access arrangement:** Click or tap here to enter text. |
| **School:** Click or tap here to enter text. | **Grade:** Click or tap here to enter text. |
| **Other agencies involved:** Click or tap here to enter text. |
| **Reason for referral:** Click or tap here to enter text. |
| **Has the client agreed to the referral?** [ ] Yes [ ] No [ ] N/A  |
| **Have the parents been notified of the referral?** [ ] Yes [ ] No [ ] N/A |
| **Referrer name:** Click or tap here to enter text. | **Referring agency:** Click or tap here to enter text. |
| **Referrer Contact Information:** Phone/Email | Click or tap here to enter text. |

**Please return via fax to 613-546-3881 or via email to** **intake@maltbycentre.ca**

**Maltby Centre**

**31 Hyperion Court, Suite 100, Kingston, ON K7K 7G3**

**613-546-8535 / Maltbycentre.ca**