**Referral Form for Counselling Services at WECHC**

*Please note: There is currently a waitlist for counseling services. All referrals will be handled in a confidential manner and will become part of your medical file. If you do not have a medical provider at WECHC a new record will be created with the information you provide. Please speak to our Privacy Officer for more information.*

**Client information:**

|  |  |  |
| --- | --- | --- |
| Legal Name (as it appears on your health card): |  |  |
| Name you go by: |  | Age: |
| Date of Birth: | Gender: |  |
| Is the client aware of, and agreeable to, the referral? | * yes
 | * unsure
* no
 |

**Referral source information:**

|  |  |  |
| --- | --- | --- |
| Today’s date: |  |  |
| Referral source: | * primary provider
 | * agency
 |
|  | * self
 | * parent
 |
| Referral source’s contact information: |  |  |

**Residence and family information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Client resides with (name): |  |  |  |
| Relationship to referred client: |  |  |  |
| Address: |  |  |  |
| City: |  | Province: | Postal Code: |
| Home phone:Can a message be left at this number? |  | Other phone:Can a message be left at this number? |  |

**Health information:**

|  |  |  |
| --- | --- | --- |
| Health card number : |  | expiration date:version code: |
| Medical Provider: |  | Other : |

**Other agency involvement:**

|  |  |  |
| --- | --- | --- |
| Name of agency | Past involvement (list dates) | Current involvement (list dates) |
|  |  |  |
|  |  |  |
|  |  |  |

**Reason for requesting counselling:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of client:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is there a history of any of the following?**  | **No** | **Past** | **Current (within the last 6 months)** | **Details** |
| Diagnosis of mental illness |  |  |  |  |
| Medication for mental illness |  |  |  |  |
| Hospitalization for mental illness |  |  |  |  |
| Thoughts of suicide |  |  |  |  |
| Suicide attempt |  |  |  |  |
| Self-harming behavior |  |  |  |  |
| Legal involvement |  |  |  |  |
| Violent behavior |  |  |  |  |
| Physical abuse |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is there a history of any of the following?** | **No** | **Past** | **Current****(Within the last 6 months)** | **Details** |
| Sexual abuse |  |  |  |  |
| Emotional abuse |  |  |  |  |
| Witness of family violence |  |  |  |  |
| Other trauma |  |  |  |  |
| Elder abuse (emotional, physical, financial, neglect) |  |  |  |  |
| Head injury with loss of consciousness |  |  |  |  |
| Intellectual challenges/learning disabilities |  |  |  |  |
| Diagnosis of dementia or memory loss |  |  |  |  |

**Guardian information (regarding a child or youth):**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent name: |  | Parent name: |  |
| Name of individual(s) who have legal custody:\*If parents are separated please provide the name(s) of all people who are formally recognized as having custody\* |
| Address of Custodial Guardian  |
| City: |  | Province: | Postal code: |
| Home phone: |  | Other phone: |  |

Is the referral for an immediate family member (spouse, child, sibling or parent) of a WECHC employee? Yes or No

**Thank you for taking the time to complete this form. Only fully completed forms will be processed.**