SOURCES
TRAUMA COUNSELLING
PROGRAM

CLIENT REFERRAL FORM-PROFESSIONAL REFERRALS ONLY

SECTION 1: CLIENT INFORMATION

Client Name (First and Last Name): _____

Gender: _____ **Date of Birth (DD/MM/YYYY):** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone: _____ **Email:** _____

Can we leave a message? ☐ **Yes** ☐ **No**

Preferred Language of Service: _____

Support is required in the following areas: _____

SECTION 2: REASON FOR REFERRAL

☐ **Depression**	☐ **Attachment**	☐ **Family conflict and/or violence**
☐ **Anxiety**	☐ **Suicidality**	☐ **Concurrent disorder - Diagnosed**
☐ **Trauma**	☐ **Homicidality**	☐ **Concurrent disorder - Suspected**
☐ **Legal Issues**	☐ **Parenting**	☐ **Other (Please describe):**
☐ **Substance Use/Addiction**	☐ **Self-Harm**	_____

SECTION 3: RFERRAL SOURCE (Professional Referrals Only)
For self-referrals please call 604.335.6035

Name: _____ **Relationship to Client:** _____

Agency (if applicable): _____ **Best Time to Reach You:** _____

Phone: _____ **Email:** _____

Please confirm the client has agreed to this referral: ☐ **Yes** ☐ **No**

How did you hear about our services? _____

Please forward the completed form to trauma.counselling@sourcesbc.ca