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| Diversity Counselling New Zealand **Community Counselling Referral Form** |  |



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| Date |  |

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| First Name |  | Surname |  |
| Preferred Name |  | Date of Birth |  |
| Gender |  |
| Address |  |
| Mobile |  |
| Can we leave Voice Message? Yes / No | Can we send a TXT? Yes / No |
| Email |  |
| Can we contact you by email? Yes / No |
| Ethnicity |  |
| First language Spoken |  |
| Additional language Spoken |  |
| Is interpretation service required? | Yes / No  |
| If yes, interpretation language |  |
| Client/Guardian given consent for this service?  | Yes / No  |
| Parent/ Guardian name (if client is 16 or under) |  |
| Parent/ Guardian mobile or email |  |
| Preferred counselling session methods (Face to Face, Zoom, WhatsApp, Phone etc.) |  |
| Reasons for seeking counselling (e.g., health, relationship, finance, stress, anxiety, trauma) |  |
| **Referrer Details:**  |
| Agency Name |  |
| Referrer’s Name and Position |  |
| Referrer’s Contact details | Phone: Email: |