45 Miriama Street, PO Box 349, Taumarunui 3946
07 895 6393 07 895 6394 taumarunuicounselling@xtra.co.nz

Referral Form

Details of Person/Agency Referring – Please Complete

Name of Person/Agency Referring: _____ Date of Referral: _____

Telephone Number of Referrer: _____ Email: _____

Address: _____

Details of Person Being Referred – Please Complete

First Name: _____ Surname: _____

Address: _____

Telephone Number: _____ Cell Phone: _____

Ethnicity: _____ Gender: _____ Age: _____

Date of Birth: _____ No. of Children: _____ (If any in Full Time Care – Funding Purposes)

Employment Status: _____ Email: _____

Brief Reason for Referral: _____

_____

If the Referred Person is under the age of 17 have the Parent(s)/Guardian(s) been involved with the referral?

Yes / No (briefly explain): _____

Name of Parent/Guardian: _____

Address: _____

Telephone No: _____

Relationship to Person Referred: _____

I have discussed this referral with the Client Referred or the Parent/Guardian of the Client.
The Client gives permission for this referral and to be contacted or to arrange an appointment with TCS.

Signature of Client: _____ **Date:** _____
(Or Parent/Guardian)

Signature of Referrer: _____ **Date**: _____