



Clinical Advisory Services Aotearoa

REFERRAL TO SPECIALIST COUNSELLING SERVICE

Client Being Referred

Surname: First Names:

Date of Birth/...../..... Ethnicity Gender Male / Female (circle one)

Iwi affiliation

Address: (street)
..... (suburb) (town/city/postcode)

Telephone Home (0)..... Work (0)..... Mobile (02).....

Email:

Preferred method of contact:

Details of Deceased/Attempter

Surname: First Names:

Date of Birth/...../..... Ethnicity Gender Male / Female (circle one)

Date of Death/Attempt:/...../.....

Relationship to above Client:

Location and Method of Death/Attempt:

.....

Additional Information

Would the client prefer the Maori counselling service? YES NO (circle one)

Additional Referral Information:

Referrer Details

Referred by Date/...../.....

Organization Telephone (0)..... Email

Client Consent to Referral and Client Information Brochure given YES NO (circle one)

CONFIDENTIAL when filled in