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| **Forward all referrals to** cathywaltersgilhuly@gmail.com**Cathy Walters-Gilhuly MSW., RSW.****Clinical Member of ATSA****Please call** 519-400-1967 if you have questions. Randy Scott Clinical Services randyscottclinicalservices.ca  |

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| REFERRING Agency |  |
| REFERRING AgencyContact |  |
| REFERRING AgencyAddress |  |
| REFERRING AgencyPhone Number  |  |
| REFERRING AgencyEmail Address  |  |
| REFERRING AgencyBilling Information  |  |
| **DATE** |  |

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| **CLIENT INFORMATION** |
| Client Name |  |
| **Date of Birth** |  | **Marital Status** |  |
| **Gender**  |  | **First Language**  |  |
| Address |  |
| **Phone (Home)** |  | **Phone (Work)** |  |
| **Email Address** |  |  |  |
| **Preferred appointment type**  | Phone or Zoom  |
| **Current Employer**  |  |
| **Length of Employment** |  |
| **Education** | :  |

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| **REASON FOR REFERRAL**With the client, comment on the problem, length of problem, impact on his/her life and what he/she wants from counselling |
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| **GENERAL PROBLEM AREAS** |
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| **OTHER INFORMATION** |
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| **Two Way Consent/Release of Information:** |
| I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent and authorize the release and disclosure by Randy Scott Clinical Services, its subcontractors, or supervisors of any information, report, document, assessment, record, material, statement or part there of concerning myself or \_\_\_\_\_\_\_\_\_\_, my child, ward or charge to the\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ its employees, agents, or designates. Clients have the right to ask for some personal information to be withheld provided it does not fall beyond the limits of confidentiality. Furthermore, I consent that the\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, its employees, agents, or delegates may release any information, report, document, assessment, record, material, statement or part there of concerning myself or \_\_\_\_\_\_\_\_, my child, ward or charge to Randy Scott Clinical Services, its subcontractors, or supervisors. This document has been verbally reviewed with the client on (d/m/y) ……./……/…… By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referring Agent NameThis document has been verbally reviewed with the client on (d/m/y) ……./……/……. By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Work TherapistIf signed by the client, then the client has had the opportunity to review this document and sign it with the individual named below. This consent is granted for six months from the date signed.

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| **CLIENT** | **Social Work Therapist/ Referring Agent Name**  |

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