RESOLVE THERAPY

Mental Health and Trauma Counselling Referral Form

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Referral Date:		Client Name:
Program/Community:		Date of Birth:
Referror's Name:		Status #:
		LANDLINE: Mobile/app: Email:
Phone:		Address:

Counselling requested for:

□ Adult □ Couple □ Family □ Youth 12-18

If couple or family, name(s) of additional clients: Under 18 provide Parent/Guardian Name:
_____

Is client aware of this referral? □ Yes □ No

Primary presenting issue: _____

If applicable, indicate if the client is a:

□ Former Indian Residential School Student
□ Family member of a former Indian Residential School student
□ Former Indian Day School student
□ Family member of a former Indian Day School student
□ If the client is seeking services regarding the issue of Missing & Murdered Indigenous Women & Girls

Name of School Attended: _____