

# Caring Minds Counselling Referral Form

## Client Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency name and Contact: \_\_\_\_\_

## Referral Source

Name and contact details of referrer \_\_\_\_\_

Relationship to client: \_\_\_\_\_

## Reason for Referral

Please describe the primary reasons for seeking counselling:

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## Funding (If any – please include NDIS number)

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## Location of Sessions

Please indicate your preferred day and location for counselling sessions:

- Caring Minds Counselling rooms on a Tuesday or Thursday
- Outreach available on Tuesday, Wednesday or Thursday

\_\_\_\_\_

For children under 10 years old, it is preferred to meet with a parent or caregiver for the initial session.

Please provide the name and contact details for this person below:

- Name \_\_\_\_\_
  - Contact details \_\_\_\_\_
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P: 0426 174 484

E: [cassie@caringmindscounselling.com.au](mailto:cassie@caringmindscounselling.com.au)

Thank you for your referral, we will be in touch within 24 hours. We look forward to working with you.

Please email this referral to [cassie@caringmindscounselling.com.au](mailto:cassie@caringmindscounselling.com.au)