

Workbridge Counselling Services

Professional Counselling Referral Form



Please complete form and fax to 9764 9597

Name of referring Organisation / Agency _____

Referral Date

Contact Name _____

Organisation _____

Phone Number _____

I understand referring the client below will incur a payment of \$90.00 inc gst per session to my organisation.

Client Name: _____

(First)

(Last)

Address: _____

Suburb: _____

Birth Date: ____/____/____

Age: ____

Gender:

Male

Female

Home Phone: (____) _____

Mobile Phone: _____

How did you find our services? Website Newspaper Brochure Other

NUMBER OF SESSIONS REQUIRED (Please circle)

6

12

OTHER

WHAT TYPE OF COUNSELLING IS REQUIRED?

Alcohol/Substance Abuse

Yes / No

Motivation

Yes / No

Anger Management

Yes / No

Obesity

Yes / No

Anxiety

Yes / No

Obsessive Compulsive Behaviour

Yes / No

Career Planning

Yes / No

Pain Management

Yes / No

Depression

Yes / No

Relationships

Yes / No

Disability & Illness

Yes / No

Self Esteem and Confidence

Yes / No

Domestic Violence

Yes / No

Workplace Stress

Yes / No

Mental Health Issues

Yes / No

Work Preparation

Yes / No

Other / Comments

Thank you for referring to Workbridge Counselling Services

ADMIN USE ONLY:

Referral Recorded

Yes

Referral No

Date _____

Staff Notified

Appointment made

Yes

Staff Initial

Invoice Created Yes

Date _____

Phone: 03 9764 1274 - Head Office - 14 Kingsley Cl, Rowville VIC 3178

Cranbourne, Pakenham, Pearcedale, Oakleigh, Box Hill, Brighton, Rowville, Lilydale, Healesville, Warburton