Diversity Counselling New Zealand

REFERRAL FORM

□ **Adult** □ **Youth (13-17 yrs.)** □ **Child**

First Name: _____ **Surname:** _____

Preferred name: _____ **Date of Birth:** _____/_____/_____ **Gender:** ____

Address: _____

Mobile: _____ **Email:** _____

Can we leave voice message? Yes / No **Can we send a text?** Yes / No

Ethnicity: _____

First Language Spoken: _____ **Additional Language spoken:** _____

Client needs interpretation services? Yes / No

if Yes, Interpretation language_____

Client/Guardian given consent for this referral? Yes / No

Parents/Guardian Name *(if relevant)*: _____ Phone: _____

Client working with other agencies? If yes, who are they? _____

Reason for referral: _____

_____

_____

_____

_____

_____

_____

Referrer's Name: _____ **Position:** _____

Agency: _____ **Address:** _____

Phone: _____ **Email:** _____

Date: _____ **Signature:** _____

Please send this form to contact@dcnz.net