H.E.A.L. Holistic Counselling Referral

1391 101st St Street North Battleford
Box 520 N. Battleford SK S9A 2Y8 Phone: 306-480-6651 **Fax:** 306-445-6444

Date of Referral:		
Last Name:	Middle Name:	First Name:
Current Address:		
Main Phone:	☐ Call & Identify ☐ Leave Message & Identify ☐ Don't Call	
Cell Phone:	☐ Call & Identify ☐ Leave Message & Identify ☐ Don't Call	
Email:	☐ Contact by email ☐ Don't contact by email	
Date of Birth: M D Y	Current Age:	
Treaty Number:		
Gender: ☐ M ☐ F ☐ Other (please identify):		
Band Name:	☐ Moosomin ☐ Saulteaux ☐ Red Pheasant ☐ Thunderchild ☐ Sweet Grass ☐ Poundmaker ☐ Little Pine ☐ Other (please specify):	
Emergency Contact Information		
Contact Person:	Relationship:	
Main Phone:		
Address:		
City/Town:	Province:	Postal Code:
Critical Health Care Needs		
Do you have any critical health care needs such as allergies, diabetes or other conditions that could cause an emergency health situation? ☐ Yes ☐ No		
Referral Person:	Phone: ( )	
Relationship Information		
Current Relationship Status:	☐ Married ☐ Common-Law ☐ Widowed ☐Divorced ☐ Separated ☐ Single-No Partner ☐ Single-with Boyfriend ☐ Single-with Girlfriend	
Total number of biological children:		
Name of partner in current relationship:		
Gender of current partner: ☐ M ☐ F ☐ Other (please identify):		
How long has the client been with his/her partner?		
Other Agency Involvement (Current)		
☐ Addiction Services ☐ Battlefords Mental Health Services ☐ Sexual Assault Centre ☐ Interval House ☐ Adult Probation ☐ Victim Services ☐ BRT6 ☐ Ministry of Social Services ☐ Other		
Previous Counselling		
Has the client had counselling previously? ☐ Yes ☐ No		
Harm / Abusive Information		
Is the client currently a suicide risk? ☐ Yes ☐ No		

Has the client mentioned harming others? ☐ Yes ☐ No
Doctor's Care and Medication Information
Is the client currently under a doctor's care? ☐ Yes ☐ No ☐ I don't know If yes, please provide the following:
Name of Doctor:
Is the client currently taking any medications? ☐ Yes ☐ No
Hospitalization Information
Has the client had any psychiatric hospitalizations? ☐ Yes ☐ No ☐ I don't know
Problems and Abuse
Peer relationship problems? ☐ Yes ☐ No ☐ I don't know
Family relationship problems? ☐ Yes ☐ No ☐ I don't know
Alcohol problems? ☐ Yes ☐ No ☐ I don't know
Drug problems? ☐ Yes ☐ No ☐ I don't know
Has the client been abused in the past? ☐ Yes ☐ No ☐ I don't know
Drug / Alcohol Treatment
Has the client had previous drug or alcohol treatment? ☐ Yes ☐ No
Consent to Communicate with Referral Personnel:
☐ Yes ☐ No Notify the referral person when counselling referral is received and counselling commences.
☐ Yes ☐ No Notify the referral person when counselling is terminated or discontinued (2 missed appointments will result in the client file being closed)
Other than the above information where Yes is checked the counsellor will not disclose any other details to the referral person.
24 hour notice is required for clients to cancel appointments
This is a private practise counselling clinic. There is a fee for service if clients do not have coverage.
Does this person have health coverage for counselling services? ☐ Yes ☐ No
If Yes who do they receive coverage though? ☐ Non-Insured Health Benefits/ Treaty Status ☐ EAP Coverage ☐ Other Please List
Please do not forward this referral form unless all signatures have been obtained.
Client's Consent to Counselling
I, ____________________________________ have agreed to be referred to H.E.A.L Holistic Counselling. (Please Print Name) ______________________________ ______________ Client's Signature Date ______________________________ ______________ Referral Person's Signature Date