



# Northwest Counselling Centre Ltd. Since 1987

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### REFERRAL FOR:

Name: \_\_\_\_\_ Program: \_\_\_\_\_

DOB: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

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

Home phone: \_\_\_\_\_ Mess: \_\_\_\_\_ Work phone: \_\_\_\_\_ Mess: \_\_\_\_\_

Employer: \_\_\_\_\_

Name

DOB

Parent or Guardian: \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has client been seen at our Centre before? Yes/No Counsellors name \_\_\_\_\_

Name seen under (if different from above) \_\_\_\_\_

What is the Primary issue? (answer all that apply)

Marriage/Relationship \_\_\_\_\_

Family \_\_\_\_\_

Life Skills \_\_\_\_\_

Sexual abuse \_\_\_\_\_

Prenatal support \_\_\_\_\_

Work \_\_\_\_\_

Adoption related \_\_\_\_\_

Stress \_\_\_\_\_

Sex \_\_\_\_\_

Grief/Loss \_\_\_\_\_

Anxiety \_\_\_\_\_

Drugs/Alcohol \_\_\_\_\_

Depression \_\_\_\_\_

Loneliness \_\_\_\_\_

Parenting \_\_\_\_\_

Self-confidence \_\_\_\_\_

Parent/Teen \_\_\_\_\_

Other \_\_\_\_\_

Physical \_\_\_\_\_

Child abuse \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Initial Appointment: \_\_\_\_\_ Counsellor: \_\_\_\_\_

Client informed of L/C and N/S policy Yes ( ) No ( )