

E.L.J.Counselling

Referral form

Name/s.....

Address.....

.....

Phone #.....

Email address/es

Family Physician..... **Phone #**.....

Any other medical practitioners/counsellors with whom you are currently working:

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Contact Phone #.....

Prescribed medication.....

Please provide a snapshot of your concerns

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Disclosure Statement : All counselling is strictly confidential. Records relating to your counselling, including the fact you are a client, may only be released with your written permission, or by a court order. All communication and records related to your therapy are kept confidential. There are exceptions to this contract of confidentiality: your therapist is required by law to report to the relevant authorities any child abuse concerns regarding a child being harmed or in danger of harm, if clients present as a risk to self or others , or if client's records are subpoenaed by a Court of Law. Please sign below to indicate you understand the above. Also to indicate you agree to participate in sessions via video counselling.

Signed.....Date

Signed.....Date