

Thank you for referring your client to Healing Steps Counselling. Please complete this form with the client's informed consent and email it to healingsteps.connect@gmail.com. This form is not for urgent or crisis referrals.

REFERRER DETAILS

Referrer's full name

Date of referral

Profession

☐ GP

☐ Psychologist

☐ Psychiatrist

☐ Social worker

☐ School professional

☐ Allied health

☐ Other

Practice / organisation

Provider no. (optional)

Phone

Email

CLIENT DETAILS

Client's full name

Preferred name

Date of birth

Pronouns (optional)

Age

Phone

Email

Address (optional)

CONSENT AND CONTACT

☐ Client has consented to this referral

☐ Consent not yet obtained

Date consent obtained

Preferred contact method

☐ Email

☐ Phone

CLIENT REFERRAL FORM - PRESENTING NEEDS

REASON FOR REFERRAL

- | | | |
|---|--|--|
| ☐ Anxiety / worry | ☐ Depression / low mood | ☐ Stress / burnout |
| ☐ Trauma | ☐ Grief and loss | ☐ Emotional regulation |
| ☐ Neurodiversity (Autism / ADHD) | ☐ Family conflict | ☐ Relationship difficulties |
| ☐ Parent support | ☐ School-related concerns | ☐ Life transitions |
| ☐ Self-esteem / confidence | ☐ Other | <input type="text"/> |

PRESENTING CONCERNS

Briefly describe the current concerns, duration, impact and relevant recent changes.

RELEVANT BACKGROUND

Include relevant psychosocial, developmental, medical, family or trauma history.

GOALS FOR COUNSELLING

What outcomes is the client seeking, and what would progress look like?

CURRENT SUPPORTS

- | | |
|---|---|
| ☐ General practitioner | ☐ Psychologist |
| ☐ Psychiatrist | ☐ Paediatrician |
| ☐ School counsellor | ☐ Social worker |
| ☐ Occupational therapist | ☐ Speech pathologist |
| ☐ Support coordinator | ☐ Other <input type="text"/> |

Names and contact details of involved services (where relevant and consented):

CURRENT MEDICATIONS

Include medication name and dose if relevant and known.

RISK AND SAFETY CONSIDERATIONS

- | | |
|--|---|
| ☐ No known immediate risk | ☐ Current suicidal thoughts |
| ☐ History of self-harm | ☐ Previous suicide attempt |
| ☐ Family or domestic violence | ☐ Child protection concerns |
| ☐ Substance use concerns | ☐ Aggression / violence risk |
| ☐ Significant trauma history | ☐ Other <input type="text"/> |

Provide relevant details, current safety plan and actions already taken:

IMPORTANT

Healing Steps Counselling is not an emergency or crisis service. For immediate danger call 000 or attend the nearest emergency department. Urgent/high-risk referrals require appropriate crisis or specialist pathways.

Confidential referral information - send only with client consent.

APPOINTMENT INFORMATION

Preferred appointment times

☐ Weekday morning

☐ Weekday afternoon

☐ Weekday evening

☐ Flexible

ADDITIONAL INFORMATION

DOCUMENTS ATTACHED

☐ Care plan / referral letter

☐ Relevant medical information

☐ Assessment report

☐ Safety plan

☐ Other

REFERRER DECLARATION

I confirm that the client has consented to this referral and that the information supplied is accurate to the best of my knowledge. I understand that Healing Steps Counselling will assess suitability and may contact the client and/or referrer for further information.

Referrer's name

Date

Signature (typed or handwritten after printing)

FOR HEALING STEPS COUNSELLING USE ONLY

☐ Accepted

☐ Waitlist

☐ More information required

☐ Redirected

~~Discontinued~~

Notes