Counsellor Referral Form

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

Date of Referral:	Student aware of referral? YES NO
Referral Source (please circle) SELF SCHOOL (Staff name): Family Member (name):	
CLIENT DETAILS	
Name:	DOB:
EMERGENCY CONTACT DETAILS	
Name:	Phone:
Relationship:	Email
Can we contact this person about your appointments: YES NO	
REFERRER DETAILS	
Name:	Phone:
Relationship:	Email:
Can we contact this person about your appointments: YES NO	
Reason for referral: *Please provide some detail*	
Are you aware of any current risk to the student: YES NO *If yes, please provide some detail.*	

PO Box 971 Karratha WA 6714 • P: (08) 9144 1081 • F: (08) 9185 2124
E: admin@stlukescollege.wa.edu.au • W: www.stlukescollege.wa.edu.au

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I provide permission for my student to seek the support through appointment(s) with the St Luke's College Counsellor. Information will be treated confidentially by the counsellor and the College. My child may withdraw from counselling at any time. The College will always seek to work collaboratively with families where appropriate.

Signed: _____

Parent name: _____

Date: _____