

# General Referral for Counseling



Please send completed form to email at  
[iconoclastrlw@hotmail.com](mailto:iconoclastrlw@hotmail.com) or fax to 404-920-3295

## Personal Information

First name:	Last name:
Age:	Date of birth:
Ethnicity:	Religion:
Marital status:	Number of children and their ages:
Sex/gender:	Date:

Home address:

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Telephone:

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Who do they live with?

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## Details of Person Referring

First name:	Last name:
Title:	Role performed while referring:
Contact number:	Contact email:

## Reason for Referral/Incident Details

Provide details of why the person is being referred for counseling:

For example:

- Aggression
- Always tired
- Bullying (victim/bully)
- Sadness
- Motivation
- Fighting
- Self-harm
- Risk to others
- Scared
- Impulsive
- Change in behavior
- Worried
- Defiant
- Poor work
- Stealing
- Drug use
- Excessive drinking
- Nervous

List those behaviors (above and extra ones) for which the individual is being referred:

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Description of any significant incident or examples of this behavior:

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Actions taken by the person referring (or anyone else):

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How urgent is a referral required? (0 – not important, 10 – extremely important)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any risks to the individual or others that should be highlighted:

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Anything else that should be taken into account?

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