Centacare
Catholic Family Services

# School Counselling Program
## Initial Referral Form

**Date of Referral**
DD | MM | YYYY

**Name of Person making the Referral**

**Relationship to the Student**

**Counsellor**

**Class Teacher and Room Number** (IF APPLICABLE)

## Student Details

**Name**
FIRST | LAST

**Address**
ADDRESS
SUBURB | STATE | POSTCODE

**Date of Birth**
DD | MM | YYYY

**Year Level / Age**

**Is the student aware of the referral?**
☐ Yes ☐ No

## Parent/ Caregiver Details

**Name**
FIRST | LAST

**Date of Birth**
DD | MM | YYYY

**Home Phone Number**

**Mobile Phone Number**

**Email Address**

**Is the parent/guardian aware of the referral?**
☐ Yes ☐ No

**Address**
ADDRESS
SUBURB | STATE | POSTCODE

**Name**
FIRST | LAST

**Date of Birth**
DD | MM | YYYY

**Home Phone Number**

**Mobile Phone Number**

**Email Address**

**Is the parent/guardian aware of the referral?**
☐ Yes ☐ No

**Address**
ADDRESS
SUBURB | STATE | POSTCODE

Are there Family Court Orders or Intervention Orders in place for the family? ☐ Yes ☐ No
A copy of the orders must be presented for counselling to commence.

Please turn page over

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### Reasons for Referral

### Suggested Counselling goals/outcomes

**Thank you**