

SOCIAL WORK REFERRAL FORM

Note: Psychotherapy and social work are regulated health professions in Ontario but are not covered under OHIP. Potential clients are encouraged to speak with their insurance provider about counselling services provided by a Registered Social Worker, to determine eligibility and approved rates of coverage. Counselling services are available to anyone over the age of 18.

CLIENT IDENTIFICATION

Name _____ Date of Birth (DD MM YR) ____/____/____

Address _____ City _____ Postal Code _____

Telephone _____ Alternate phone _____

Email _____

REASON(S) FOR REFERRAL (please check all that apply):

<input type="checkbox"/> Thoughts of harm to self or others <input type="checkbox"/> Feelings of hopelessness / worthlessness <input type="checkbox"/> Sadness / depressed mood <input type="checkbox"/> Loss of interest <input type="checkbox"/> Feeling overwhelmed <input type="checkbox"/> Worrying excessively / panic attacks <input type="checkbox"/> Generalized anxiety <input type="checkbox"/> Social anxiety	<input type="checkbox"/> Trauma / PTSD <input type="checkbox"/> Trouble with coping <input type="checkbox"/> Social isolation <input type="checkbox"/> Low self esteem <input type="checkbox"/> ADD / ADHD <input type="checkbox"/> Strong emotions / anger <input type="checkbox"/> Grief / loss <input type="checkbox"/> Alcohol and / or substance use <input type="checkbox"/> Loss of employment / financial stress	<input type="checkbox"/> Partner and / or family conflict <input type="checkbox"/> Parenting support <input type="checkbox"/> Adjustment to illness / injury / change <input type="checkbox"/> New diagnosis / prognosis <input type="checkbox"/> Caregiver stress <input type="checkbox"/> Advance care planning
--	--	--

Additional information:

Referral Source :

Self <input type="checkbox"/>	Primary Health Care Provider <input type="checkbox"/>	Other _____
-------------------------------	---	-------------

Name _____ Date _____ Telephone _____

If this is an EXTERNAL REFERRAL
 Please fax completed form to 905-372-4977
 or mail to 18 Spencer Street E., Cobourg, ON K9A 1C2

Tel: (905) 372-2369 | info@carolynhigginson.com
 Thank you for your referral!