Allura Sex Therapy Centre
Counselling Referral Form

Date of Referral: ________________

Is the client aware of this referral? ☐ **Yes** ☐ **No**

CLIENT INFORMATION

Name:

____

Birthdate:_____/_____/______(MM/DD/YYYY) Age: ______ Gender: ______________

Address: ____

City:______________________ Province: ____________ Postal Code: ____________

Phone (home): __________________ May we leave a message? ☐ **Yes** ☐ **No**

Phone (home): __________________ May we leave a message? ☐ **Yes** ☐ **No**

Email: __________________________________ May we email? ☐ **Yes** ☐ **No**

REFERRING PROFESSIONAL

Name:

____

Practice:

____

Address: ____

City:______________________ Province: ____________ Postal Code: ____________

Phone: ___________________ Email: ____

REASON FOR REFERRAL/PRESENTING PROBLEMS:

Thank you!