Counselling Connection

Referral Form

36 King St. East, Unit B2
Bowmanville, ON
L1C 1R3
Phone: (905)-233-4424
Fax: 905-248-3478
info@counsellingconnection.ca

Referring Agency/ Professional: _____

Client Name: _____

Address: _____

Phone Number: _____

Reason for Referral:

- □ Behaviour concerns
- □ Social/emotional concerns
- □ Family/couples counselling
- □ Eating Disorder

Additional comments:

_____

_____

_____

Completed by: _____ Date: _____

Please List any Attachments

- □ _____
- □ _____