INTAKE REFERRAL – COMMUNITY COUNSELLING

Referral Information:

Referring Agency: _____

Referring Contact name:_____

Contact Number: _____

Email:_____

Client Information:

Name: _____

D.O.B: _____

Contact Number: _____

May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No

***Please note: Email correspondence is not considered to be a confidential medium of communication**

Type of Counselling Required:

☐ Anger Management	☐ Healthy Relationships	Other: _____
☐ Communication	☐ Coping Skills	_____
☐ Goal Setting	☐ Stress Management	
☐ Confidence/Self Esteem	☐ Substance Use	

EFRY Hope and Help for Women Community Counselling Program Contact Information:

For inquiries regarding referrals please call: 416-400-4481
Please email referrals to: jwebb@efryhope.com