Family Counselling Centre
Everyday Challenges. Positive Solutions. Changed Lives.

Tel-Check
Client Referral Form

PLEASE FAX REFERRAL TO: 519-336-8517

OR FOR INQUIRIES CALL 519-336-0120 EXT. 251 TO LEAVE A MESSAGE

Client Contact Information

Name: _____ **DOB:** _____

Phone #: Res. _____ **Cell #** _____ (circle preferred number)

Address: _____

Has consent been provided by client? Yes _____ **No** _____

Initial contact should be made with: Client _____ **Other** _____

Contact Information and Relationship to client: _____

_____

Living Alone: If No, How many live in home	Yes	No
Safety Check:	Yes	No
Friendly Phone Visit:	Yes	No
Health Check:	Yes	No

Economic Status (Circle)
Employed
Ontario Works/SA/ODSP
Pension
Unemployed

Marital Status (Circle)
Single
Married/Partnered
Separated/Divorced
Other

Does client have current medical symptoms of concern? Yes No (Circle)
Details:
Special Instructions when communicating with client:

Referral Source: Agency: _____ **Name:**_____

Contact #_____ **Date of Referral:** _____