

Counselling Service

Dunedin Referral Form



Date: _____ Referred By: _____

Agency/Service: _____

Phone: _____ Email: _____

Client Details

Name: _____ DOB: _____

Address: _____ Postcode: _____

Phone/Mobile: _____ Email: _____

Ethnicity/Iwi Affiliation: _____ First Language: _____

Children (Names & Ages): _____

Family Consent to Referral *(please tick)*

What are the issues that you think the Counselling service can address?

Other Agencies involved:

Please forward either by email to Counselling@FamilyCare.org.nz or by mail to:

The Counselling Service
Anglican Family Care
266 Hanover Street
Dunedin 9016

Please feel free to phone or email to discuss this referral with us further:

Phone: (03) 477 0801 or 0800 FAM CARE Fax: (03) 477 0888

Email: Counselling@FamilyCare.org.nz