



Referral Form

Mountains Adolescent & Family Counselling Service

Name:

Age: Date of Birth:

Address:

Phone: Mobile:

Mother: Age:

Address:

Occupation: Phone:

Father: Age:

Address:

Occupation: Phone:

Adolescent at home? Yes No

Fostered/Adopted/Step Family? Yes No

Drug/alcohol problems? Yes No

Who will attend counselling?

School/Employment details:

Referral Agency:

Contact: Phone:

Reason for referral:

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Other Agencies Involved:

Other relevant information:

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Is the young person aware the referral is being made? Yes No

Upper Mountains
Naomi Murray
p: 4782 4436
f: 4782 9106

Lower Mountains
Peter Hurley
p: 4754 5411
f: 4754 5606