VENEKA
THERAPY & CONSULTING

Mental Health Counselling Referral Form

Cell: 587-880-2673
Fax 403-770-2457
Email: intake@venekatherapy.ca

Referral Date:	Client Name:
Program/Community:	Date of Birth (**required**):
Referrer's Name: Referrer's phone number:	Status number (**required**): Band name:
	Landline: Mobile/app: Email: Facebook:
• *Please note that status number and DOB are required for billing through Pacific Blue Cross* • *Consent forms MUST be signed by legal guardian*	Address:

Counselling requested for:

□ Adult □ Couple □ Family □ Youth (age 10-17) □ Child (10 & under)

If couple or family, name(s) of additional clients:

_____

For clients under the age of 18, please provide Parent/Legal Guardian name:

_____

Is client (or guardian in case of a minor) aware of this referral?

□ Yes □ No

Primary presenting issue: _____