SELF-REFERRAL/REFERRAL FORM – please fax to: 778-732-0448 or Email counsellor@movingforwardfamilyservices.com

Date: ___________________ Referred by: ____________________________

Agency Name (if applicable): ____

Agency Phone: _____________________________ e-mail: ___________________________________

NOTE:WE ONLY OFFER SERVICES IN SURREY AT THIS TIME.
Thank you for the referral. Our low barrier counselling services are in high demand. While we will make every effort to work with your referred client, we also request you consider additional referrals to other resources. **We are not a funded service** (we operate without any core funding from local, provincial or federal government sources) and request that you also refer the client to any of the service providers (direct government and non-profit organizations) who are funded to provide counselling services. We may refuse referrals from government ministries and health authorities who are themselves responsible to provide counselling directly to clients and/or who fund agencies to provide such services.

Choose one option: ☐ No wait services with a Clinical Counsellor Location (circle one or more) **in Surrey or Abbotsford** Fees $50 individual $65 couples/families (if client has coverage i.e. insurance, fees will be higher and once that is maximized these lower fees will be charged).	☐ $20-30 Intern Counsellors on practicum. Waits are 6-8 weeks **in Surrey only.** Fees $20 Individual $30 couples/families
☐ Client can only pay __________. Waits may be up to 20 weeks **in Surrey only.** Proof of low income required. Note: Services are not free – clients are expected to "Pay What You Can."	
☐ Referral Source will pay for the counselling service. Referral source will pay __________ per session	
☐ Client advised that missed appointments without 24 hours' notice may result in a missed appointment charge, and that multiple missed appointments may result in cancellation of services	

Client's First Name: ______________________________Last Name: ____________________________

Gender: __________________ Birth date: _________________ (Y/M /D)

Parent/Guardian name(s): (if applicable) ____

CLIENT CONTACT: whenever possible we prefer to contact client by e-mail first and by text message second. If client does not have e-mail or cell phone then we will call.

Client e-mail: ___________________________________ Client cellular: _______________________

Home phone: _________________________ Can I leave detailed message? Y/N (If no, please assist client in calling us for an appointment at 778-321-3054).

Address: ____

Reason for referral / Special instructions: ____

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