Referral Form

TRIELLO COUNSELLING SERVICES

INFORMATION FOR YOUR CLIENT:

- Triello Counselling Services provides counselling and psychotherapy to children (7+), adolescences, adults and seniors. The modality is individual and family counselling.
- We provide services through Practice Better, a secure and compliant online platform for videoconferencing.
- Telephone sessions are provided for those who do not feel comfortable with video sessions.
- We will make two attempts to contact the client and leave two voicemails, when consent is provided.
- Self- referral is preferred.
- Triello Counselling Services may not have availability and clients may be placed on a waitlist.
- Clients are encouraged to call us directly to check on the status of their referral.
- An initial phone consultation will be made with client prior to scheduling an appointment.

INFORMATION FOR REFERRING PROVIDERS:

- It is important that your client is aware that the referral is being made and provided you consent.
- Please understand that Triello Counselling Services will not directly share information with you on behalf of your client without receiving their (the client) consent.
- We do not require a referral from a physician or nurse practitioner for services.
- Referring provider can contact us to inquire further information.

INFORMATION FOR SELF-REFERRALS:

- To self-refer yourself, please complete the form below if you would like or email us to set up a phone consultation.
- Please be informed that Triello Counselling Services may not have availability and you may be placed on a waitlist (if you choose). A list of other providers can be provided to you if you need to meet with someone sooner.
- Feel free to check-out www.triellocounsellingservices.com or contact 613-209-2191 to inquire more about requesting an appointment or to schedule your free 15-min phone consultation.

HOW TO SUBMIT A REFERRAL:

- Please **fax** the completed referral form to: **709-400-2422**
- Please ensure each referral is **faxed** individually.

- IF YOUR CLIENT NEEDS IMMEDIATE HELP, PLEASE DIRECT THEM TO THE NEAREST EMERGENCY DEPARTMENT OR CALL 911.

REFERRAL FORM

TRIELLO COUNSELLING SERVICES

Date of Referral (DD/MM/YYYY):______________________________________

CLIENT INFORMATION

Legal Name

First Name: Last Name:

Preferred Name (If applicable)

Date of Birth (DD/MM/YYYY):

Gender

☐ Female ☐ Trans Woman ☐ Two-Spirit ☐ Genderfluid ☐ Non-binary

☐ Male ☐ Trans Man ☐ Genderqueer ☐ Androgynous ☐ Other

Client Identification Information

Registered Name:_______________________________Indian Act Registration Number (status or treaty card): _______________________

The purpose of providing this information is to see client's eligibility of coverage for NIHB or IRS RHSP.

Client Address:

Address: ____

City:_________________________________Province:___________________Postal Code:________________Unit #: ___________

CLIENT OR DELEGATE CONTACT INFORMATION

By listing telephone numbers or an email address below, the referral source confirms that the client consents for us to call/ email them regarding this referral. Triello Counselling Services will refrain from communicating unrequired personal information until consents are verified.

Client/ Delegate Telephone Number(s)/ E-mail Address (Specify type: home, office, cell, etc.)

Contact information below is for: ☐ Client ☐ Delegate If Delegate, please specify relationship to client: ________________________

Type:__________**Tel #1**:_______________________________________Consent to voicemail messages: ☐ Yes ☐ No

Type:__________**Tel #2**:_______________________________________Consent to voicemail messages: ☐ Yes ☐ No

E-mail Address: ____

EMERGENCY CONTACT**

Name: Relationship: Phone:

CUSTODY STATUS (For youth under the age of 16)

Custody Status:

☐ Joint Custody (Please fill out contact information for both guardians)

☐ Sole Custody (Please fill out contact information for the sole guardian)

☐ Lives with both parents/ Married/ Common Law (Please fill out contact information for both guardians)

☐ Other (e.g. CAS), please specify: ___________________________

1. Guardian Name:____________________________________
   Telephone:____________________________________
2. Guardian Name: ____________________________________
   Telephone: ____________________________________

REFERRING PROVIDER INFORMATION

Name

First Name: Last Name:

Contact

Phone: Email:

Please select one of the following:

☐ Family Physician ☐ Psychiatrist

☐ Nurse Practitioner ☐ Other:___________

1. REASON FOR REFERRAL

Please indicate the primary reason for referral (specify current symptoms, presenting problems and history)

Please select the service you're seeking for your patient:

☐ Individual Counselling

☐ Family Counselling

☐ Specific Treatment (e.g. CBT, DBT):

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All forms completed should be faxed to **709-400-2422**

Completed by: Date:

________________________ ________________________ ________________________

(Print name & credentials) (signature) (dd/mm/yyyy)