Christchurch Resettlement Services

Pegasus partners in health kia ataahua ki te tangata

# Culturally & Linguistically Diverse Counselling Service Referral

| Office use only | |
|---|---|
| Client ID: | |
| W/L Letter: | |
| Allocated: | |
| Counsellor: | |
| Dis. Letter: | |
| Closed: | |

**DATE:** _____

**CLIENT NAME:** _____ (Male / female)

**Address** _____

_____

_____

_____

**Phone:** _____

**DOB:** _____

**Ethnicity:** _____

**Is an interpreter needed?.** Yes / No

**Language Spoken:** _____

**G.P.** _____

**Referred by:** _____

**Service:** _____

**Postal address:** _____

_____

**Phone no:** _____

**Time in NZ :** _____

**1. Reason for referral (including diagnosis if available) :**

_____

_____

_____

**2. Kessler Scale (if known) :** _____

**3. Risk/Safety:**

**Family Violence:** ☐ *Reason:* _____

**Mental Health:** ☐ Reason: _____

☐ _____