Date of referral:

Counselling Referral Form

Full Name:		
Address:		
Date of Birth:		
Contact Number:		
Email:		
Tick all that apply:	☐Depression or mood changes ☐Suicidal ☐Major Mental Illness ☐Self-Harm ☐Anxiety ☐Legal Issues ☐Withdrawal ☐Chronic Relapse ☐Disordered Eating ☐Greif/Loss ☐Housing Issues ☐Poor Support	☐School Problems ☐Work Problems ☐Relationship Problems ☐Family Problems ☐Personality Changes ☐Alcohol ☐Drugs ☐Anger ☐Low Self-Esteem ☐Other:

By signing this form, you authorise Smile Of A King Foundation to forward this information onto a qualified counsellor.

Sign: Date:

For Office Use Only

Counsellor Assigned:

Invoice Total:

Date Invoice Paid:

Number of sessions paid for: