



Referral Guidelines

1. To refer a potential client for Art Therapy, please complete this form and return it, along with any other relevant information via e-<mailto:bella@inkbrush.com.au> or Fax to 02) 62829002. Self-referred clients may bring this form along to their first appointment.
2. With the client's consent, the Art Therapist may contact you to discuss the client's progress. If you are happy to be contacted, please tick
3. If you would prefer **not** to be contacted, please tick

Client Information

Name: _____ Date of Birth & Age: _____

Preferred name: _____ Occupation: _____

E-Mail Address: _____ Phone number: _____

Referring clinician

Name & practice/org. _____

Email & phone no: _____

Assessment

Group sessions

Individual Sessions

Both Individual & Group Sessions

Client is being referred

For:

Please list the main reasons for the referral

Indicate all desired outcomes that apply

<input type="checkbox"/> Developing/maintaining interpersonal relationships	<input type="checkbox"/> Acknowledging/ expressing emotional needs
<input type="checkbox"/> Developing / increasing social skills	<input type="checkbox"/> Anger management strategies
<input type="checkbox"/> General wellbeing/ quality of life	<input type="checkbox"/> Reduction of anxiety
<input type="checkbox"/> Increased self-confidence	<input type="checkbox"/> Address depression/ low mood
<input type="checkbox"/> Symptom management	<input type="checkbox"/> Other...

o Name

o Date: _____ Signed, _____