



STATE OF CONNECTICUT
 Department of Rehabilitation Services
 Deaf and Hard of Hearing Counseling Unit

Counseling Unit Referral Form

Date of Referral: _____

Referral Source:

- Self: _____
- Family: _____ Relationship: _____
- School: _____ Position: _____
- Other: _____ Position: _____

Referral Phone #: _____ **Referral Email:** _____

Court Involvement: No Yes - Type: _____

Other Agencies Currently Involved: _____

Reason for Referral: _____

Client Demographic Information

Name: Last _____ First _____

Address: _____

Mode of Communication: _____

Contact: Home Phone _____ Cell _____

VP _____ Email _____

DOB: _____ **Age** _____ **Gender:** _____

Please circle any of the following areas that you would like to work on:

Workplace	Identity	Parenting	Sibling issues	Transitions in life
Marital/Relationship Issues	Stress	Communication Issues	Family Issues	School
Sexual Orientation	Women Issues	Men Issues	Abuse	Self-Harm
Self Concept	Control Issues	Worry	Anxiety	Loneliness
Other:				