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

Counseling Unit Referral Form
****Please complete all of the form****
****This information is confidential****

Referral By: **Date of Referral:** _____

- ☐ Self
- ☐ Family**:**_____ Phone Number: _____
- ☐ School: _____ Phone Number: _____
- ☐ Agency: _____ Phone Number: _____

Other Agencies Currently Involved: _____

_____

Court Involvement: ☐ No ☐ Yes - Type: _____

Reason for Referral: _____

_____

_____

Client Demographic Information

Name: Last _____ First _____
Address: _____
Mode of Communication: _____Oral _____ASL _____Signed English _____Other _____
Contact: Home Phone _____ Cell _____
VP _____ Email _____
DOB: _____ Age _____ Gender: _____

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

☐ Workplace	☐ Identity	☐ Parenting	☐ Self Concept	☐ Loneliness
☐ Marital/ Relationship Issues	☐ Stress	☐ Communication Issues	☐ Family Issues	☐ School
Other:				

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