Elm Grove Centre
41097 Western Rd Alma, PE, C0B1K0
therapy@elmgrovecentre.ca
Tel: 902-806-2257 Fax: 902-853-2342

Date of Referral: ___________________________

EGC OFFICE INTAKE DATE: ___________________________

Referred By: Professional ☐ Self ☐
Preferred Language: English ☐ French ☐

Name:	Date of Birth:
If a Minor (both parents' names):	Custody: Minor's Legal Name:
Mailing address :	

Phone Number:_____________________________________ Home ☐ Mobile ☐ Work ☐
Email: ____ Leave message: Yes ☐ No ☐
Preferred Method of Contact for Appointment Confirmations and Reminders: Call ☐ Text ☐ Email ☐

Emergency Contact: Phone Number: Relationship:

Will insurance be used to aid in covering the cost of the counselling sessions? Yes ☐ No ☐

******If planning to utilize insurance, please note the importance to verify with your insurance provider coverage availability for M.S.W., R.S.W. social work designation. Method of payment is required to be secured in order to reserve your session spot.*

Insurance Provider/Policy #/Certificate #:

Additional Payment Method: eTransfer ☐ Credit Card ☐ Check ☐ Cash ☐
(eTransfers can be sent to therapy@elmgrovecentre.ca)

OFFICE USE ONLY: We use a secure practice management system to keep information safe and confidential. We like to keep a credit card on file, it is encrypted, so only the last 4 digits are shown. Or we require payment prior to the first session.
Cardholder: Credit card #: Expiry: Security #:

Physician:	Diagnosis/Current Medication:
Referral Source:	Consent to Collaborate with: Referral Source Yes ☐ No ☐

Other Collaborating Professionals: Yes ☐ No ☐ (Collaboration Consent Form will be sent as per request.)
Additional Information:

Please indicate any you are experiencing/seeking support with:

- ☐ Anxiety/panic
- ☐ Depression
- ☐ Low self-esteem
- ☐ Relationship difficulties
- ☐ Use of alcohol or recreational drugs/indicate frequency ____________
- ☐ Trauma
- ☐ Grief
- ☐ Suicidal thoughts
- ☐ Self harm behaviors
- ☐ Feeling generally overwhelmed
- ☐ Feeling disconnected

Please briefly describe your interest in counselling at this time. Your therapeutic goals/wellness plan will be developed with your therapist.

☐ Individual Counselling ☐ Equine Psychotherapy

Preferred Location: ☐ *Elm Grove* ☐ *Tignish* ☐ *Summerside* ☐ *Video Conference*
Frequency: ☐ *Weekly* ☐ *Bi-Weekly* ☐ *4-Week Interval* ☐ *Other* ______________________