COUNSELLING SERVICES

……………………………………………………………………………………………………

CONSENT FORM

Information shared in the counselling sessions is confidential. The Counsellor will protect and promote the client’s identity and integrity during and after the sessions.

……………………………………………………………………………………………………

DATE…………………………………… TIME………………………. …………….

SEX…………………………………….. AGE……………………………………….

REFERRED BY………………………… SELF-REFERRAL……………………….

FULL NAME……………………………………………………………………………………….

CELL PHONE NUMBER…………………………………………………………………………

OTHER CONTACT NUMBER………………………………………………………………….

RELIGION………………………………………………………………………………………

RESIDENCE ………… ………………………………………………………………………..

CONSENT

I……………..………………………DATE……………………….VOLUNTARILY

CONSENT TO PARTICIPATE AS A COUNSELLEE

SIGNATURE……………………………………………… DATE…………………………..

NAME OF COUNSELLOR…………………………………DATE…………………………

FIRST SESSION……………………………………………………………………………

SECOND SESSION ……………………………………………………………………………………

THIRD SESSION ………………………………………………………………………………………

GROUP SESSION………………………………………………………………………………………