

KARI KOKKO, MSW, RSW, SEP

Located at: *The Refuge Centre for Healing and Recovery*
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CLIENT CONTACT FORM

Date: _____

Name: _____
Age: _____ Birthdate : _____
Gender: _____

Address: _____

City: _____ Province : _____ Postal code: _____

Email: _____

Home phone: _____ / ___ ok to leave / ___ discreet message / ___ do not leave
message only message

Cell phone: _____ / ___ ok to leave / ___ discreet message / ___ do not leave
message only message

How did you find out about these services?

PRIMARY PHYSICIAN / MEDECIN

Name: _____ Number: _____

EMERGENCY CONTACT

Name: _____ Number: _____

Relationship to you: _____

___ I give permission for Kari to contact this person if she has been unable to reach me directly

*IF CLIENT IS A MINOR

Legal guardian: _____

Relationship to client: Parent Other: _____

Address: _____ City: _____ Prov.: _____

Phone number(s): _____