

***A MEASURE OF HEALTH:***  
*THErapy, CONSULTATION, AND EDUCATIONAL SERVICES*

STEPHANIE GREIVE, BSW, MSW, R.CSW  
(BCCSW REGISTRATION # 5276)

**CLIENT CONTACT INFORMATION**

**Some verbal and written communication from me to you is necessary from time to time to provide service to you. Every effort is made to be discreet in contacting you. This form specifies how and where you prefer to be contacted.**

**NAME:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

Street Address

City

Province

Postal Code

**I can receive written communication at this address:    Yes    No**

**PHONE: Home** \_\_\_\_\_ **May a message be left at this number?**                      Yes              No

**Work** \_\_\_\_\_ **Whose number?** \_\_\_\_\_ **May messages be left?**    Yes    No

**Cell** \_\_\_\_\_ **Whose number?** \_\_\_\_\_ **May messages be left?**    Yes    No

**Cell** \_\_\_\_\_ **Whose number?** \_\_\_\_\_ **May messages be left?**    Yes    No

**Special instructions:** \_\_\_\_\_

**I/we give our authorization to be contacted by A Measure of Health: Therapy, Consultation and Educational Services as outlined above.**

\_\_\_\_\_  
**NAME**    **SIGNATURE**    **DATE**

\_\_\_\_\_  
**NAME**    **SIGNATURE**    **DATE**