care community counselling

ebm

CARE COMMUNITY COUNSELLING CENTRE

REFERRAL FORM FOR PROFESSIONALS

Client's Name:	Date of Birth (if known):
Client's Address:	
Telephone number(s) client can be contacted on:	
Name & address of client's GP practice:	GP's name & telephone no:

1. What are the main problems for which you are referring this client? (e.g. low mood, panic attacks, shyness, worrying, bereavement, etc.)

2. How long have they had these problems? (e.g. weeks, months, years?)

3. Is this client currently seeing anyone for counselling / psychotherapy, drug or alcohol problems, or for any other mental health support? ☐**Yes** ☐**No**

If **Yes**, please give details.

4. Is there anything else that you think it is important for us to know about this client?

(Please attach a separate page if you need more space.)

Your Name:	Occupation:
Your Address for Correspondence:	
Telephone number(s) you can be contacted on:	

Signature: ______________________ Today's date: ______________

OFFICE USE ONLY

Date Received:	Tel contact with referrer?	Comments: