**48 Cambridge Gardens**

**Hastings**

**East Sussex**

**TN34 1EN**

**Tel 01424 428300**

[**www.counsellingplus.org**](http://www.counsellingplus.org)

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| --- |
| **Office only**  **Date received** |

**Referral Form**

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| --- | --- |
| Client Name | Client Address  Postcode |
| Date of birth | Telephone |
| Email Address |
| **Please confirm client is aware of referral and agrees to you sharing their data with CPC** (we will destroy referral if consent is not given)  Yes | Does client consent to having a message left on the phone?  Yes No |
| **Please confirm that client can access remote sessions** Yes | Please mark all options suitable for client  Tel Zoom Face to face |
| Referring Agency | Referral date |
| Referrer name | Referrer Tel No |
| What has prompted the referral at this time? Please give full details of presenting issues.  Does the client have a psychiatric diagnosis? Yes No  If you have marked ‘yes’, please give details of diagnosis.  Is the client reliant upon drugs and/or alcohol? Yes No | |
| Does the client present any of the following risks?  Suicidal ideation/plan Yes No  Thoughts/plan of harming others Yes No | |
| If you have marked ‘yes’ for either of the above risks, please give further details. | |

**All referrals to be made using this form.**

**Email to** [**admin@counsellingplus.org**](mailto:admin@counsellingplus.org)**, post, or Fax to 01424 443005**