**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**

|  |  |
| --- | --- |
| Client Name  Date of birth | Client Address  Postcode |
| Please confirm that you have made the client aware that there is only limited capacity for funded sessions and a contribution will be discussed.  **Yes** **Please tick** | Telephone |
| Email Address |
| Please confirm you have made the client aware that they must be alone and in a confidential space for a telephone assessment.  **Yes** **Please tick** | Does client consent to having a message left on the phone?  Yes  No |
| Please confirm the client is aware of your referral and agrees to you sharing their data with CPC  **Yes** **Please tick** | Please mark all options suitable for client for counselling sessions  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  Is the client reliant upon drugs and/or alcohol? Yes  No  Does the client present with suicidal ideation/plan? Yes  No  Does the client present with thoughts of harming others? Yes  No | |
| **If you have marked ‘yes’ for any 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)**, or post to address above**