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**REFERRAL FORM**

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| --- | --- |
| **Date of referral** |  |
| **Name of referrer** |  |
| **Referrers contact number** |  |
| **Referrers email address** |  |
| **Referrers organisation** |  |
|  |  |
| **Full name of individual** |  |
| **Date of Birth** |  |
| **Address** |  |
|  |  |
|  |  |
| **Postcode** |  |
| **Phone number (mobile or landline)** |  |
| **Email** |  |
| **Preferred method of contact?** |  |
| **Can we leave a message?** | **YES NO** |
| **Is the individual already engaged in any other mental health therapy?**  ***(GP, IAPT, CBT, Counselling?)*** |  |
| **Reason for referral** |  |
| **Any known concerns?**  *(alcohol/ drug abuse, anger, violence, etc)* | **YES *(please state)* : NO** |

**FOR OFFICE USE ONLY**

|  |  |
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| **Staff Name** |  |
| **Date of Initial Contact** |  |