**Adult Services - Counselling Referral Form**

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| Office use / Client ID:  |

CONFIDENTIAL

**Please complete the form clearly and as fully as possible and return (marking it CONFIDENTIAL) to:**

***Hear Me, Referrals, PO Box 7010, Forfar. DD8 0BJ***

**(This form will NOT be accepted unless signed by the client aged 18 or over)**

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| --- | --- |
| **Client’s Name:** |  **Referred by:** **Date:**  |
| **Age:** | **Organisation:** |
| **Address:** | **Address:** |
| **Telephone Number:****Okay to leave a message: YES NO** | **Telephone Number:** |
| **Email:** | **Email:** |

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| **Name of GP and/or GP surgery:**  |
| **Are there any medical issues we should be aware of: YES NO DON’T KNOW****If YES, please provide more details:****Is the person a risk to others? YES NO DON’T KNOW****If YES, please provide more details:** |
| **Client’s signature** **……………………………………….. Date……………………………** |
| **OFFICE USE ONLY** |
| ***Date received:*** |  |
| ***Referral processed by:*** |  |
| ***Contact made?***  |  |