**Adult Services - Counselling Referral Form**

|  |
| --- |
| 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)**

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

|  |  |
| --- | --- |
| **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?*** |  |