REFERRAL ASSESSMENT FORM

This form is to be completed by the Referrer.

THIS FORM IS CONFIDENTIAL. It must be agreed by the client that the details set out on this form are accurate.

Name of Client: .....

Address of Client .....

.....

Client Tel No. .....

Date of Birth ..... / ..... / ..... Age: .....

Gender ☐ Male ☐ Female

Name of the organisation referring: .....

Name of the person referring
on behalf of the organisation: .....

Address of Organisation: .....

.....

Date of Referral: .....

If self-referring (name): .....

What are the presenting issues/reasons for seeking counselling?

Are you taking medication? Please list names and dosages:

Please give details of GP

Name of GP: .....
Address: .....
.....
.....
.....
Contact no: .....

Emergency Contact Details

Name / Relationship: .....
Address: .....
.....
.....
.....
Contact no: .....