48 Cambridge Gardens
Hastings
East Sussex
TN34 1EN
Tel 01424 428300
www.counsellingplus.org

Referral Form

Office only Date received

Client Name Date of birth	Client Address Postcode
Please confirm that you have made the client aware that whilst we have limited capacity for funded sessions, 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, or post to address above