

**HCS REFERRAL**

ORGANISATIONAL REFERRAL FORM

Ref No:

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| CLIENT’S NAME:  PLEASE TICK ONE OF THE FOLLOWING:  INDIVIDUAL REFERRAL  FAMILY/ SIBLING REFERRAL | | REFERRAL DATE: |
| CLIENT’S ADDRESS:  TOWN:  POST CODE:  CLIENT’S CONTACT NO:  DATE OF BIRTH:  AGE:  (If under 16 y/o please complete appendix A) | | Please circle:  OK to send post: YES / NO  OK to leave telephone message: YES / NO  OK to send text: YES / NO  REFERING ORGANISATION: …………………………….  NAME OF PERSON MAKING REFERRAL:  …………………………………………………………………………  REFERERS TEL NO: …………………………………………...  EMAIL: ………………………………………………………………  NATURE OF INVOLVEMENT:  PRESENTING ISSUES FOR REFFERAL: |
| GP Details: | | LIVING WITH:  ALONE / PARTNER / CHILDREN / RELATIVE / CARER / OTHER |
| CLIENT DISABILITY:  YES /NO  (Complete (i) if answer is yes) | | (i)Please CIRCLE the most appropriate definition  Mental Health issues Learning difficulties  Physical impairment Long standing illness  Sensory impairment Other |
| ARE THERE ANY KNOWN RISK FACTORS WORKING WITH THIS CLIENT? |  | |

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| COUNSELLOR PREFERENCE:  Male Female  No preference | METHOD OF DELIVERY:  (Subject to COVID-19)  Face-to-face  Online  Telephone |

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| OFFICE USE ONLY |
| Actions taken:  Referral Taken by................................. |
| Allocated Worker...................................  Date:......................  Location:.............................. |
|  |

PLEASE RETURN VIA EMAIL: [c.hallcounselling@gmail.com](mailto:c.hallcounselling@gmail.com) or [katielawson.hcs@gmail.com](mailto:katielawson.hcs@gmail.com)   
  
For any queries regarding a referral please contact CAROLINE on 07871528207