

**HCS Multiple Client Referral**

ORGANISATIONAL REFERRAL FORM

Ref No:

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| PLEASE TICK ONE OF THE  FOLLOWING:  INDIVIDUAL REFERRAL  FAMILY/ SIBLING REFERRAL  Please indicate how many individuals:  …………………………….…………………………….  Details of adult for HCS to contact to set sessions:  Name:  Contact Number: | REFERRAL DATE: |
| REFERING ORGANISATION: …………………………….  NAME OF PERSON MAKING REFERRAL:  …………………………………………………………………………  REFERERS TEL NO: ……………………………………...  EMAIL: …………………………………………………………  NATURE OF INVOLVEMENT:  PRESENTING ISSUES FOR REFFERAL: |
| 1.NAME:  ADDRESS:  TOWN:  POST CODE:  CLIENT’S CONTACT NO:  DATE OF BIRTH:  AGE:  (If under 16 y/o please complete appendix A)  LIVING WITH:  ALONE / PARTNER / CHILDREN / RELATIVE / CARER / OTHER  CLIENT DISABILITY:  YES /NO (Complete if answer is yes)  (i)Please CIRCLE the most appropriate definition  Mental health issues  Learning difficulties  Physical impairment  Sensory impairment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ARE THERE ANY KNOWN RISK FACTORS WORKING WITH THIS INDIVIDUAL?  3. NAME:  ADDRESS:  TOWN:  POST CODE:  CLIENT’S CONTACT NO:  DATE OF BIRTH:  AGE:  (If under 16 y/o please complete appendix A)  LIVING WITH:  ALONE / PARTNER / CHILDREN / RELATIVE / CARER / OTHER  CLIENT DISABILITY:  YES /NO (Complete if answer is yes)  (i)Please CIRCLE the most appropriate definition  Mental health issues  Learning difficulties  Physical impairment  Sensory impairment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ARE THERE ANY KNOWN RISK FACTORS WORKING WITH THIS INDIVIDUAL?  5. NAME:  ADDRESS:  TOWN:  POST CODE:  CLIENT’S CONTACT NO:  DATE OF BIRTH:  AGE:  (If under 16 y/o please complete appendix A)  LIVING WITH:  ALONE / PARTNER / CHILDREN / RELATIVE / CARER / OTHER  CLIENT DISABILITY:  YES /NO (Complete if answer is yes)  (i)Please CIRCLE the most appropriate definition  Mental health issues  Learning difficulties  Physical impairment  Sensory impairment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ARE THERE ANY KNOWN RISK FACTORS WORKING WITH THIS INDIVIDUAL? | 2. NAME:  ADDRESS:  TOWN:  POST CODE:  CLIENT’S CONTACT NO:  DATE OF BIRTH:  AGE:  (If under 16 y/o please complete appendix A)  LIVING WITH:  ALONE / PARTNER / CHILDREN / RELATIVE / CARER / OTHER  CLIENT DISABILITY:  YES /NO (Complete if answer is yes)  (i)Please CIRCLE the most appropriate definition  Mental health issues  Learning difficulties  Physical impairment  Sensory impairment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ARE THERE ANY KNOWN RISK FACTORS WORKING WITH THIS INDIVIDUAL?  4. NAME:  ADDRESS:  TOWN:  POST CODE:  CLIENT’S CONTACT NO:  DATE OF BIRTH:  AGE:  (If under 16 y/o please complete appendix A)  LIVING WITH:  ALONE / PARTNER / CHILDREN / RELATIVE / CARER / OTHER  CLIENT DISABILITY:  YES /NO (Complete if answer is yes)  (i)Please CIRCLE the most appropriate definition  Mental health issues  Learning difficulties  Physical impairment  Sensory impairment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ARE THERE ANY KNOWN RISK FACTORS WORKING WITH THIS INDIVIDUAL?  6. NAME:  ADDRESS:  TOWN:  POST CODE:  CLIENT’S CONTACT NO:  DATE OF BIRTH:  AGE:  (If under 16 y/o please complete appendix A)  LIVING WITH:  ALONE / PARTNER / CHILDREN / RELATIVE / CARER / OTHER  CLIENT DISABILITY:  YES /NO (Complete if answer is yes)  (i)Please CIRCLE the most appropriate definition  Mental health issues  Learning difficulties  Physical impairment  Sensory impairment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ARE THERE ANY KNOWN RISK FACTORS WORKING WITH THIS INDIVIDUAL? |

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

**Appendix A**

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| Relationship to child: |  |
| Who has parental responsibility: |  |
| **Parental Signatures;**  signing as a parent will be considered a declaration of lawful parental responsibility. Where there are court orders in place for others holding PR please provide details here and copies of relevant court orders: | Sign below:  ………………………………………………………………..  Date signed:  …………………………… |

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