

Helping Groups to Grow Structured Counselling Referral Form



ID No

Personal Details - Confidential Information

Referred by

Referral Date:

Name of Referrer:

Agency:

Role:

Contact Telephone Number:

Address:

Referrer email address::

Name of Case Manager/Care Co-ordinator, if applicable:

Contact Details, including Telephone Number:

Client Contact Details

Client First Name:

Client Last Name:

DOB:

Client Address:

Tel No:

Mobile No:

Preferred method of contact:

Phone mobile letter

GP:

GP Address:

GP Tel No:

Is GP aware of referral?

Yes

No

Emergency Contact:

Emergency Contact Telephone no:

List of Current Medication:

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Risk Issues:

Brief reason for referral:

Counsellors will need access to a room. Please indicate a suitable room and contact number for booking this:

Room Location:

Contact Number for room booking:

Confidentiality Agreement Declaration

I agree to this information being shared with and between agencies I am currently involved with, including my GP. I understand that this information is being shared with a view to ensuring and assisting the continuity of my care. I am aware that I can withdraw my consent to this information being shared with any or all of these agencies at any time.

Client Name:

Client Signature:

Signature of Referrer:

Date

Please send Referral, marked 'Private and Confidential' to:

Counselling Co-ordinator, Helping Groups To Grow, Building 1, St David's Park,
Jobs Well Road, Carmarthen SA31 3HB

Office Number:
01267 236862