

**Referral Form for Counselling Support via Phone / Skype**

Please complete all sections each time a request is made for counselling

Email to counselling@bemis.org.uk

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| **REFERRAL DETAILS** |
| Date of referral: |  |
| Referrer’s name: |  |
| Address: |  |
|  |
| Postcode: |  |
| Contact number: |  |
| Referrer’s email: |  |
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| **SOURCE OF REFERRAL** |
|[ ]  Self |
|[ ]  Family, friend, significant other |
|[ ]  Other (please specify below) |
|  |
| **Reason for referral**  |
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| **Referral DETAILS** |
| First Name: |  |
| Last Name: |  |
| Address:  |
| Postcode: |  |

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| **CONTACT NUMBERS** | Is it OK to leave a message?  |
| Tel: |  | Yes [ ]  | No [ ]  |
| Mobile: |  | Yes [ ]  | No [ ]  |
| Preferred day/time to call: |  |
| Email: |  |

|  |  |
| --- | --- |
| Date of birth: |  |
| Gender: Male [ ]  Female [ ]  Other [ ]  |
| Country of birth: |  |
| Cultural identity: |  |
| First language (other than English): |  |
| Interpreter required?If Yes, state what language please. | Yes [ ]  No [ ]  |

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| **COUNSELLING TYPE REQUESTED** |
| Individual [ ]  |  | Couple/family [ ]  |

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| **CONSENT**  |
| [ ]  | I confirm that the nominated client has consented to this referral and to sharing their details with relevant qualified counselors. |