**The Refresh Project Referral Form**

**T:** **07903228993 E:** **therefreshproject@empowering-action.org.uk**

**Counselling Referral Form**

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| **Please complete as much detail as possible.** **If you would like more information about our services, or support with this form, please call 07903228993 or email us at: therefreshproject@empowering-action.org.uk** **All data is held is the strictest of confidence and in accordance with Data Protection legislation.**  |

Please email back to : therefreshproject@empowering-action.org.uk

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| **Section A – Referrer Details** |
| Date referral made |  |
| Name of referring agency |  |
| Name and role of person making the referral |  |
| Phone number |  |
| Email  |  |
| **Section B – Client Details** |
| Has the client previously had counselling? |  |
| Name of referred client |  |
| Support required |  |
| Contact number/Email addressIs it safe to leave a voicemail message? |  |
| D.O.B |  |
| Gender |  |
| Religion |  |
| Address of client  |  |
| Is the client aware of the referral? |  |
| **Section D – Any specific details/information that may be relevant/you wish to share** **\*Please give an overview/context of the reason you are making the referral** |
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| **Section E – Risk Assessment (please complete with client)** |
| Is the client expecting a child? If so, how many months?  |  |
| Does the client have a disability? |  |
| Is the client dependant on any medication prescribed by a doctor? |  |
| Does the client have any support needs with alcohol or drugs? |  |
| Has the client ever caused harm to themselves or others? |  |
| Does the client have any mental health issues? Anxiety? Depression?  |  |
| Does the client have any criminal convictions? |  |
| Does the client receive support from any other agency e.g., social worker, community mental health team? |  |
| How is the client feeling and coping generally? |  |
| Are there any other issues the client needs help with? |  |

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