**Client Referral Form**

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| **Details of Referrer** | |
| Name of Organisation/Doctor | Phone Number of referrer |
| Name of Referrer | Position |
| **Details of Person being Referred** | |
| Name: | DOB |
| Address | Phone No:  How would you like to be contacted  Phone call: \_\_\_ Text: \_\_\_ |
| Gender  Male \_\_\_ Female \_\_\_ | Have you attended Counselling before?  Yes: \_\_\_ No: \_\_\_ if so when |
| Presenting issues: | |
| Are you on medication: | |
| **A member of The FORD staff will contact you to carry out an assessment and arrange counselling for you** | |
| Has the client been made aware of the contents of this referral? Yes: \_\_\_ No: \_\_\_ | |
| Please return this referral to: **The FORD Counselling & Psychotherapy Centre**  **12 Roche’s Road, Wexford. Y354EP**  **Or email to info@theford.ie** | |
| Signed the Referrer  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signed by the person being referred  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please note we do not work with people in active addiction; however, we are happy to work**

**with you in recovery**