COUNSELLING SERVICE REFERRAL FORM

Please note: referrals may only be made by health professionals, social work departments, and any other statutory or voluntary organisations.

Referral date

Referrer's details

Name

Organisation

Address

Postcode

Telephone

Email

The patient would like to apply for (please tick)

☐ Free core service

☐ Fast tracked service

Patient details

Name

Date of birth

Address

Postcode

Gender

Telephone

Email

Preferred method of communication

Can we leave a voicemail? ☐ Yes ☐ No

Can we send a text? ☐ Yes ☐ No

Reasons for referral

Is the patient on any medication for any current mental health condition? ☐ Yes ☐ No

If yes, please give details

Does the patient have any communication difficulties? ☐ Yes ☐ No

Do you have any safeguarding concerns regarding the patient at this time? ☐ Yes ☐ No

If yes, please give level of concern and details

Are there any other services involved in the care of this patient? ☐ Yes ☐ No

If yes, please give their details

What does the patient hope to gain from counselling?

The patient gives their consent to the above information being collected about them and shared with Well Beings for the purpose of assessment and service delivery.
For more information on Well Beings privacy policy, visit https://www.wellbeings.uk/privacy-policy
Please note, we cannot accept referrals for patients that do not or cannot consent to this referral being made.

☐ Please tick

Please email the completed form to Well Beings' Lead Therapist, Jackie at **jackie@wellbeings.uk**