



REFERRAL FORM

CONFIDENTIAL

Client Details

Name: Title:

Address:

..... Post Code:.....

Date of Birth/...../..... Contact Number:

Email:

Ethnic Origin: White/Irish/African-Caribbean/Indian/Asian/Other.....

Communication Method Sign Language Deaf/Blind Manual

 Lip Reader Speech

 Other

Why do you want to have counselling?

Please Give Details

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Use separate sheet for additional information if required...

Are you taking any medication?

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Do you have other professionals working with you? (this may be a social worker, CPN)

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Have you had counselling before? Yes/No

If yes, please tell us when and who with?

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Payment Methods (Please tick appropriate box) – If Paying Privately

Cheque/Postal Order – Made Payable to 'Signhealth'	<input type="checkbox"/>
Visa/MasterCard - Please fill in your credit card details below	<input type="checkbox"/>

Credit Card Details

Cardholders Name:	
Card Number:	
Expiry Date: / /	Signature Date

Surgery Details

GP Name (in capitals) Signature

GP Address

..... Post Code

Date Contact Number

Email NHS Number

I give permission for SignHealth Counselling to contact my GP/Doctor to complete the Counselling Service Referral Form.

Signature Date.....

Please Return to:- SignHealth
 5 Baring Road
 Beaconsfield
 Bucks HP8 2NB

Email: therapy@signhealth.org.uk