SALISBURY COUNSELLING SERVICE
REFERRAL FORM

Please be aware that some of this information is confidential.
Please be careful how it is treated.

About the Person being referred:

Name: _____ **DoB:** _____

Address: _____

_____

Phone: _____ **Mobile:** _____ **E-mail:** _____

Person's Doctor, Address, Phone: (if known) _____

_____

Any Relevant Medication: _____

_____

Any previous relevant history of mental health issues, counselling or psychotherapy, or psychiatric admissions or treatment:

_____

_____

_____

Presenting Issues – Reasons for Referral:

_____

_____

_____

_____

Relevant Work / Life / Home Circumstances or Stresses:

_____

_____

_____

_____

How Urgent is this Referral? _____

How Committed is the Person? _____

_____

Any other relevant information? _____

_____

_____

ABOUT YOU, THE REFERRER:

Name: _____

Address: _____

Contact Details: **Tel:** _____ **Mobile:** _____

E-mail: _____

Relationship to the Referrer: _____

_____

ABOUT PAYMENT:

Is the Client prepared / able to pay for the Counselling? Yes / No

If 'No', are you, the Referrer, prepared / able to pay for the Counselling? Yes / No

If 'Yes', for how many sessions? **Assessment only: £40.00** Yes: **plus 5 sessions:** Yes:

Or to a maximum of: …… sessions; or £ ……..

Paid by invoice: Yes: **Paid by cheque:** Yes: **or Bank Transfer:** Yes (please circle one)

If 'No", who is prepared / able to pay for the Counselling? _____

Name: _____

Address: _____

Contact Details: **Tel:** _____ **Mobile:** _____

E-mail: _____

Please keep a copy of this form. Please send this form to Salisbury Counselling Service, Salisbury Centre, 2 Salisbury Road, Edinburgh EH16 5AB: or e-mail it to: info@salisburycounselling.co.uk

Thank You for the referral!