

  
**Let's Talk**      **Counselling Service**  
**Established in 1999**  
**Referral Form**

<b>Name(s):</b>	<b>Date:</b>
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<b>D.O.B(s):</b>	<b>Age:</b>	<b>Gender:</b>	<b>Ethnicity:</b>
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<b>Address:</b>	<b>Contact Number/s:</b>
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<b>Referral Agency:</b> <b>Key Worker:</b> <b>Address:</b>	<b>GP:</b> <b>Address:</b>
<b>Contact Tel:</b>	<b>Contact Tel:</b>

<b>Referral Summary / Current circumstances / Reasons for Referral</b>
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**Psychological/ Psychiatric History**(Any previous/current diagnoses, medication, treatment)

<b>Risk Assessment</b>	<b>Past</b>	<b>Present</b>
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Suicidal Ideation:

Suicidal Attempt:

Self-Harm:

Self-Neglect:

Isolation:

Harm to Others:

Danger of Harm from Others:

Criminal Offences:

Child Protection Issues:

(Please use additional page, if needed)

Please email the referral to: [anthony@alphacares.org.uk](mailto:anthony@alphacares.org.uk)